To All Employees:

For over 175 years, Tulane University has been proud to be a vital part of the New Orleans community. One of the reasons we are an employer of choice is the rich benefits package that we offer our employees. This package is a key component of the total rewards you receive from the University.

Carefully review this Employee Benefits Guide in making decisions to best meet your needs. Our benefits package includes many options including, medical, dental, vision and life insurances as well as retirement plans and other valuable benefits. If you have benefits-related questions during the enrollment process or at any other time, please contact a Benefits Team member of the Workforce Management Organization (WFMO).

We would like to welcome new employees who are receiving this guide and wish you a successful career with Tulane University.

Workforce Management Organization  
Tulane University
The Tulane University Employee Value Proposition

**Engagement**
Our employees are motivated by the difference they make at Tulane and in the greater communities of which the university is part. We will encourage you and support you to maximize your contribution to both.

**Community**
You are not just a Tulane employee; you are a member of the Tulane community. You belong to an organization that understands that loyalty and commitment are two-way streets.

**A Sense of Place and Tradition**
An environment of intellectual curiosity, learning and research, infused with the energy of campus life, will inspire you with endless opportunities to stimulate your life and mind.

**Challenge and Growth**
The breadth of activity performed at Tulane University provides you with a wide range of opportunities to contribute. You have the opportunity to grow your job and to pursue new directions as you grow in a dynamic organization that goes beyond traditional limitations.
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About this Guide

This Benefits Guide is intended to provide a summary of the main features of the Tulane University benefits package. It is much shorter and less technical than the legal documents and contracts that govern our benefits. The University has made every effort to make sure the information in this summary is accurate; however, in the case of any discrepancy, the provisions of the legal plan documents and insurance certificates will govern.

The more you understand the various elements of Tulane University benefits, the better prepared you will be to take full advantage of the benefits we provide for you and your family. This Benefits Guide is a resource that will answer questions most employees have. We’ve also provided phone numbers of benefit plan vendors and other contacts so that you can manage your personal issues more efficiently. Finally, if you have additional questions concerning your benefits or need assistance, please do not hesitate to contact WFMO.

Who is Eligible

Employees:
- Regular Full-time Administrative Officers regularly scheduled to work 37.5 or more hours per week
- Regular Part-time Administrative Officers regularly scheduled work at least 50% of a full-time schedule

Eligible Dependents:
- Your legal spouse
- Your registered Same Gender Domestic Partner (SGDP)
- Your dependent, unmarried children up to age 21 (to age 25 if a full-time student for Medical coverage, age 26 for all other coverage), and that are not employed on a full-time basis and/or married.

Enrollment

When You Can Enroll
- New hires or Re-Hires: You have 60 days from your date of hire (or rehire) to enroll in Tulane University benefit plans. You are encouraged to complete your enrollment during your orientation. If you decline enrollment for yourself or your spouse or SGDP and children because of other Medical coverage, you may be able to enroll yourself or your dependents in University plans at a later date if other coverage ends. You must request enrollment within 31 days after your other coverage terminates.
- Current Employee: Change in Status (see “When Coverage Changes” section). You have 31 days from the date of the event to request a Status Change.
- Open Enrollment: You have the opportunity to enroll or change specified benefit plans on an annual basis in the fall each year for coverage that becomes effective the following January 1. Each year you will receive instructions and information in the Open Enrollment announcement prior to the enrollment period.
- HIPAA Special Enrollment (For Medical Coverage Only): If you decline enrollment for yourself during the plan year because you have other coverage, but have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependent(s), you must request enrollment within 31 days of the qualifying event.

When Coverage Begins

Your benefit plan coverage becomes effective on your official date of hire or re-hire, with the exception of the Tuition Waiver program and the Staff Retirement plan.
How to Enroll
To enroll or make changes, you will receive a Benefits Enrollment/Change Form with your new hire enrollment materials, by contacting the WFMO Benefits Team, or by going to the WFMO web site. If you are enrolling dependents (spouse, same gender domestic partner, and/or children), you are required to provide documentation for verification of their relationship to you. Refer to the section “Documentation for Dependent Enrollment” for documentation requirements. Your completed Benefits Enrollment Form and documentation, if applicable, should be returned to the WFMO address listed on the last page of the form.

Mandatory Coverage
You are required to be enrolled in one of the University’s Medical plans. If you have other Medical coverage, you must provide documentation within the first 31 days when first hired that provides proof of other coverage. If you waive Medical coverage on the enrollment form and do not provide proof of other coverage, you will be enrolled in the Low Option Medical plan.

In addition, you are automatically enrolled in Basic Life and Long-Term Disability insurance plans.

When Coverage Changes
During the Plan Year (January 1 to December 31), there may be instances when you could be permitted to change your benefit elections. In general, benefit election changes take place only during the Open Enrollment period. However, there are exceptions, which are briefly explained below and are governed by Section 125 of the Internal Revenue Code.

Status Changes and other Enrollment Changes
A “Status Change” permits you to modify elections after the Plan Year has begun and otherwise outside the Open Enrollment period. Status Changes can only be made under certain circumstances. In addition, the requested change must be consistent with and directly related to the Status Change event. Additionally, it must be requested no later than 31 days after the date of the event for the change request to be accepted within Internal Revenue Code guidelines. For example, if you get married, you may add your spouse to your Medical plan within 31 days of your marriage, but not later.

Examples of Status Changes include:

- Marriage
- Annulment of marriage
- Divorce
- Legal separation
- Death of a spouse or dependent
- Birth of a child
- Adoption or placement of a child for adoption
- Change in your dependent child’s status (reaches the age limit for coverage, gets married, gains or loses full-time student status)
- Change of spouse’s employment that affects their coverage
- Gain or loss of eligibility due to change in employment status of you or your spouse
- A significant change in spouse’s coverage due to his or her employment or an open enrollment period that is different from Tulane’s
- Gain or loss of dependent eligibility for coverage
Qualified Medical Child Support Order
If you become subject to or are awarded a court-ordered Qualified Medical Child Support Order (QMCSO) or legal change of custody, you may make a corresponding change to your enrollment in court-specified plans to comply with this order or judgment, even if you were not enrolled in any of the plans required by the order.

HIPAA Special Enrollment Rights
If you did not enroll yourself and any dependents (including your spouse) in the Medical plan during the Open Enrollment:

- If you and your dependents had COBRA coverage when you declined coverage and the COBRA coverage was subsequently exhausted.
- If you were covered under your spouse’s plan and lost eligibility to participate due to:
  - Legal separation
  - Divorce or annulment
  - Death
  - Termination of employment or loss of your spouse’s eligibility due to a reduction in work hours.
- If you have a new dependent as a result of:
  - Marriage
  - Birth
  - Adoption or placement for adoption.

If you wish to enroll in, or make a change to, your Medical plan participation due to one of these events, you must make the request to do so no later than 31 days following the event. Coverage will be effective no later than the first of the month following the request to enroll.

Leaves of Absence
If you are beginning a paid leave of absence, your current benefit plan deductions will be deducted from vacation and sick pay. If you are on an unpaid leave of absence, you will be billed for the premiums you owe on a monthly basis. Failure to make premium payments during unpaid leave of absence will result in a loss of coverage for the period that premiums are due. Please refer to the Health & Welfare plan Summary Plan Description for more details.

Entitlement to Medicare or Medicaid
If you, your spouse or dependents become entitled to (or lose entitlement to) Medicare or Medicaid, you may make a corresponding change to your Medical plan election.

Termination and Rehire in the Same Plan Year
In general, if you terminate employment with Tulane University during a Plan Year and are rehired prior to the end of the same Plan Year, you will automatically be reinstated in the same plans you had before your termination, unless you experienced a Status Change or similar event.

Dependent Eligibility Verification
When you first enroll, or if you change coverage mid-year due to a status change, you are required to provide documentation substantiating the eligibility of your dependent(s) within 31 days of the change or enrollment. Following are the events that require documentation and what is needed to support the enrollment or change:
<table>
<thead>
<tr>
<th>Event</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse with a last name different than employee</td>
<td>Marriage certificate or copy of a joint tax return (current or previous year only).</td>
</tr>
<tr>
<td>Child with a last name different than employee</td>
<td>Birth certificate and court document. The tax return for the parent claiming the child may be submitted instead of a court document (current or previous year only).</td>
</tr>
<tr>
<td>Dependent child over age 21, up to age 25</td>
<td>Birth certificate and a school/university document indicating full-time student status and the parent’s tax return claiming the child (current or previous year only)</td>
</tr>
<tr>
<td>Enrolling a Same Gender Domestic Partner</td>
<td>Affidavit of Domestic Partnership and one of the following:</td>
</tr>
<tr>
<td></td>
<td>• Joint bank account statement,</td>
</tr>
<tr>
<td></td>
<td>• Joint utility bill,</td>
</tr>
<tr>
<td></td>
<td>• Mortgage, lease, or rental agreement,</td>
</tr>
<tr>
<td></td>
<td>• Copies of you and your SGDP’s driver’s license showing common address.</td>
</tr>
</tbody>
</table>

You must provide the documents listed above to WFMO within 31 days from your initial enrollment period or Status Change if one of the above situations applies to you and your family. If documentation is not received in a timely manner, the election or change requested will not be accepted. Legible copies of required documents (in English) are acceptable.

**When Coverage Ends**

Your benefit coverage will end on the last day of the month in which:

- Your regular work schedule is reduced to less than 50% of full-time benefits eligible
- Your employment with University ends due to resignation, termination or death
- You stop paying your share of the coverage during an unpaid leave of absence, unless you are continuing payments

Your dependent(s) coverage ends:

- When your coverage ends
- The end of the month in which they turn 25
- The end of the month they lose full-time student status
- The end of the month they no longer receive over half of their financial support from you or your current or former spouse or SGDP
- The end of the month in which they get married

**Continuation of Benefits (COBRA)**

If you leave Tulane you may have the option to continue certain benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA) for a limited period of time. If you are entitled to COBRA benefits, you will receive a notice stating your right to choose to continue benefits provided by the plan. You have 60 days to accept coverage or lose all rights to benefits.
Once COBRA coverage is chosen, you are required to pay for 102 percent of the cost of coverage. Please contact WFMO should you, your spouse, or your dependent become eligible for COBRA coverage or if your dependent should no longer qualify for coverage.

The following details the length of time you or your dependent will be entitled to COBRA benefits:

**Qualifying Event Beneficiary Coverage**
- Termination or reduced hours
- Divorce, legal separation or Death of Employee
- Loss of “dependent child” status

**Duration**
- Employee, Spouse and Dependent Children: 18 months
- Spouse and Dependent Children: 36 months
- Dependent Child: 36 months

**Protection from Loss of Medical Coverage**
The Health Insurance Portability and Accountability Act (HIPAA) protects you from loss of medical coverage if you change jobs. Your new employer’s plan cannot deny or postpone coverage for “preexisting conditions” before notifying you in writing, of:
- the existence and terms of any pre-existing condition exclusion under the plan and
- your right to demonstrate creditable coverage (and any applicable waiting periods)

A certificate of group health coverage will be provided when you or a dependent lose coverage under a Tulane University medical plan. You may need this certificate for your new group or individual plan to provide evidence of your prior coverage.

**Imputed Income for Same Gender Domestic Partners**
You should be aware that the Internal Revenue Code requires you to pay taxes on the “Fair Market Value” of the domestic partner portion of Medical, Dental and Vision coverage. Imputed income is reported on your W-2 Form as taxable wages. Please consult with your tax advisor to discuss the implications of imputed income for your personal situation.

**Paying for Your Benefits**
The University pays for a portion of your Medical coverage and 100% of your Employee Assistance Plan, Basic Life and Business Travel Accident insurance. If you elect any coverage that is either partially or 100% employee paid, the cost will be deducted from each paycheck. Medical, dental and Vision insurance offered by Tulane University are “pre-tax” qualified as governed by the Internal Revenue Code. Because your contributions are made before taxes are taken out of your paycheck, your taxable income is reduced. That helps you save on taxes. Employee costs for benefits are located on the WFMO web site.
Benefit Plan Highlights
The key components of our benefit plan are *Maintaining Health & Income, Protecting & Building Financial Security, Promoting Well-Being & Fitness* and *Enriching Self & Spirit*.

Maintaining Health & Income

Medical Benefit Plans
Our medical plan offers a choice between three preferred provider organization (PPO) options through United HealthCare (UHC). These options provide a wide variety of coverage, including hospital, surgical, physician, and prescription drugs.

Dental Care
Maintaining oral hygiene is an important part of maintaining your overall health. Tulane University offers optional dental coverage, at discounted group rates, which provides for routine care, basic and major services, and orthodontia for children.

Vision Care
Vision benefits, which are offered by providers in the EyeMed network, typically cover 100 percent of charges for an annual eye exam and the cost of eyeglasses or contact lenses with low copayments.
**Long-Term Disability (LTD) Insurance**
Protecting your income is equally as important as protecting your health. The University offers a LTD plan which provides a replacement income of 66 2/3% of base salary in the event of an illness or injury that keeps a plan participant from work longer than 90 days. If you are enrolled in the Retirement and receiving LTD benefits, the insurance company will pay the retirement plan contribution on Tulane’s behalf.

**Protecting & Building Financial Security**

**Basic Term Life Insurance**
You are provided 1.5 times annual salary (to a maximum of $50,000) in basic term life insurance at no cost to you. The University also purchases basic dependent life insurance in the amount of $2,000 for your spouse and each dependent child.

**Supplemental Employee & Dependent Life and Voluntary Coverage**
Tulane University also offers supplemental life and AD&D coverage. You can purchase .5 up to 5 times your annual salary, with up to 3 time’s annual salary without evidence of insurability. Employees can elect up to $150,000 life insurance for their spouse and up to $20,000 for each child.

**Voluntary Accidental Death and Dismemberment**
This coverage pays a benefit to you or your designated beneficiary in the event of an accident resulting in the death of or certain dismembering injuries to the covered person. You may elect up to $500,000, and dependent coverage is a percentage of your election.

**Business Travel Accident Insurance**
This coverage pays a $100,000 benefit to your designated beneficiary in the event of a business travel-related accident resulting in the death of or certain dismembering injuries to the covered person.

**Flexible Spending Accounts**
The Internal Revenue Service (IRS) allows money to be deposited into Flexible Spending Accounts (FSAs) on a pretax basis to pay for qualified out-of-pocket health care and dependent care. This benefit can result in significant tax savings.

**403(b) Faculty & Administrative Officer Retirement Plan**
The University contributes up to 10% of your salary, depending on your annual salary. You are eligible to participate after two years of full-time employment. Plan participants have numerous investment options to choose from through Fidelity Investments and TIAA-CREF.

**403(b) Tax-Deferral Plan**
The Tax Deferral Plan allows you to save for retirement on a pre-tax basis, thereby lowering your taxable income. Plan participants have numerous investment options to choose from through Fidelity Investments and TIAA-CREF.

**457(b) Deferred Compensation Plan**
This plan gives eligible employees an additional opportunity to defer compensation, above the limits for the University 403(b) plan, as defined by the Internal Revenue Code.
Promoting Well-Being

Employee Assistance Program
This program is designed to assist you when you are dealing with personal problems that affect their relationships at home and at work. The University recognizes that you and your family sometimes need to address problems in a confidential, professional manner.

TU Wellness Programs
United Healthcare offers tools and resources to achieve and maintain a healthy lifestyle, and gift card rewards for completing Health Risk Assessments. Some of the other tools and programs available to you and your spouse include Biometric screenings, online and telephonic health coaching and information that helps to leading a healthy lifestyle. Sponsored by the University, the Plus One program offers various physical fitness events and activities.

Enriching Self and Spirit

Tuition Waiver
The Tuition Waiver Program entitles you and/or your dependents to attend the University and receive exemption from payment of tuition for credit courses. The program provides for up to 6 credit hours per semester. You and your dependents are eligible upon full-time employment.

Vacation
Administrative Officers receive four weeks of vacation per year.

Holidays
Tulane offers you a very generous holiday schedule.
Medical Plan Highlights
The University offers you a choice of three Preferred Provider Organization (PPO) plans through UnitedHealthcare (UHC). A PPO is a managed care plan that has arrangements with doctors, hospitals and other providers of health care. The plan does not require you to select a primary care physician and participants are encouraged to use network providers to receive higher benefit levels.

Everyone’s health care needs are different. That’s why it’s important to carefully decide which Medical plan will work best for you. In choosing a Medical plan, you should ask yourself several questions and consider your answers as you evaluate each of the University’s Medical plans:

- How much healthcare is needed for me and my family?
- What will it cost me?
- Am I more concerned about the cost of my monthly contributions or my out-of-pocket cost?

All three Medical plan options provide comprehensive medical coverage. The Plans provide benefits for your covered medical expenses when you are diagnosed and treated for a non-occupational illness or accidental injury.

<table>
<thead>
<tr>
<th></th>
<th>High Option (Plan #10)</th>
<th>Mid Option (Plan #9)</th>
<th>Low Option (Plan #13)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visit Copayment</strong></td>
<td>$25</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$250</td>
<td>$2,500</td>
<td>$500</td>
</tr>
<tr>
<td><strong>-Single</strong></td>
<td>$500</td>
<td>$5,000</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>-Family</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance (Plan Pays)</strong></td>
<td>90%</td>
<td>60%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$1,750</td>
<td>$7,500</td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>-Single</strong></td>
<td>$3,500</td>
<td>$15,000</td>
<td>$6,000</td>
</tr>
<tr>
<td><strong>-Family</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>In-Patient &amp; Out-Patient Hospitalization</strong></td>
<td><strong>Coinsurance After Deductible</strong></td>
<td><strong>Coinsurance After Deductible</strong></td>
<td><strong>Coinsurance After Deductible</strong></td>
</tr>
<tr>
<td><strong>Annual Wellness Exam</strong></td>
<td>$25</td>
<td>Not Covered</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Vision Exam</strong></td>
<td>$25</td>
<td>Not Covered</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$50</td>
<td>80% After Deductible</td>
<td>$50</td>
</tr>
</tbody>
</table>
How the Medical Plans Work
To determine what benefits you may be eligible to receive, it's important you understand the following payment provisions that apply to the administration of the Medical plans. These provisions include:

- Deductibles
- Copayments
- Coinsurance
- Out-of-Pocket Maximums
- Lifetime Maximum Benefits

Deductibles
The deductible is the amount you pay each calendar year before the plan starts to pay benefits for network or non-network care. Once you have satisfied your deductible, the coinsurance amount will apply. The maximum family deductible limits the number of individual deductibles your family has to meet each year. When two family members satisfy the family maximum deductible, the plan will treat all other family members as if they had satisfied the individual deductible. However, no single family member can apply more than their individual deductible amount in eligible expenses to the family deductible.

Copayments
Copayments are flat dollar amounts you pay for certain covered services using in-network providers. After you pay the required copayment, the plans will pay the remainder of all eligible charges. In general, when you obtain routine care (doctor's office visits, preventive and well child care, etc.) under the UHC plans your copayment is $25. Copayments do not get applied to the deductible.

Coinsurance
Coinsurance is the percentage of covered expenses both you pay and the UHC pays. The plans share of covered expenses differs depending on the UHC plan you elect. The coinsurance amount also depends on whether you use network or non-network providers.

The coinsurance percentages will apply until you reach your annual out-of-pocket maximum, at which point the plan pays 100% of your covered expenses for the rest of the calendar year.

Note that the UHC Medical plans pay benefits based on a negotiated charge when you use network providers; any charge above this amount made by the provider is not your responsibility. In contrast, if you use a non-network provider, the plans will pay benefits based on the recognized "Usual, Customary, and Reasonable" (UCR) charge. Any charges above UCR are your responsibility.

Annual Out-Of-Pocket Maximums
The annual out-of-pocket maximum includes any deductible and coinsurance amounts you pay for your share of eligible charges. Once your share of eligible charges reaches the out-of-pocket maximum, UHC pays 100% of most eligible expenses for the rest of that calendar year.
Lifetime Maximum
Medical plans limit the amount of benefits they pay for an individual. Each UHC Medical plan has a lifetime maximum benefit of $5,000,000 per enrolled member, network and non-network expenses combined.

Network Benefits
The myuhc.com web site allows you to search the UHC provider network anywhere in the U.S. If you need medical care, make an appointment with one of the providers in the network. Since the doctors you will see in the network have an agreement with the plan, you will not have to worry about filing claims or paying charges over the UCR amount.

Covered Expenses
Certain procedures, services and supplies are covered under the plans. To avoid unexpected out-of-pocket expenses, you should ensure that you and covered dependents are thoroughly familiar with the terms of the plan as provided in the insurance certificates. If you have any questions, contact phone numbers are listed in the Contacts section of this Guide and the back of the UHC I.D. card.

Out-of-Area Dependents
If you have a covered dependent who resides outside a UHC network you may want to consider whether the provider network has providers where your dependent(s) live before choosing coverage. This is important because it will influence how and if benefits will be paid for your dependent(s). Tulane also maintains a special Medical plan for employees and dependents that reside outside of a UHC network. Contact WFMO if you think this applies to you and/or your dependents.

Prescription Drug Plan Highlights
The UHC Medical plans all have the same copayment structure for prescription drugs and supplies. You automatically have prescription drug coverage if you enroll in one of the UHC plans.

<table>
<thead>
<tr>
<th></th>
<th>Retail Pharmacy</th>
<th>Mail Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayment</td>
<td>31 Day Supply</td>
<td>90 Day Supply</td>
</tr>
<tr>
<td>Generic (Tier 1)</td>
<td>$10</td>
<td>$25</td>
</tr>
<tr>
<td>Preferred Brand (Tier 2)</td>
<td>$30</td>
<td>$75</td>
</tr>
<tr>
<td>Non-Preferred Brand (Tier 3)</td>
<td>$50</td>
<td>$125</td>
</tr>
</tbody>
</table>

To get a prescription filled, take your prescription to a UHC participating pharmacy and show your member ID card. When the pharmacist fills your prescription, they will transmit your prescription claim electronically to Medco, the pharmacy benefits manager that works with UHC to provide this coverage. When you pick up your prescription, simply pay the applicable copayment. You are not required to submit any receipt or paperwork if you use a network pharmacy. To see if a pharmacy is participating, check www.myuhc.com. If the discounted cost of the prescription is less than one of the applicable copayments, you will be charged the discounted amount.
Many brand medications have a less expensive generic equivalent available. Obtaining generic drugs whenever possible can provide you with savings directly (by paying a lower copayment) and/or indirectly (because you save money for the plan - which ultimately benefits you). Ask your doctor to prescribe generic drugs whenever possible. The prescription drug component of the Medical plans has a list of brand name drugs that are considered “preferred”. Any drugs listed as “non-preferred” have the highest copayments.

The list (also referred to as a “formulary”) of preferred drugs can be found at www.myuhc.com. This is updated periodically.

Mail Order Prescription Drug Plan
You should consider using the mail order program if you have prescriptions that you take on an ongoing basis (greater than 90 days). Under this program, you may obtain a 90-day supply of maintenance medications through the mail order pharmacy administered by Medco. A maintenance medication is a drug which is prescribed for regular consumption for a prolonged period of time depending on a patient's medical condition. Most prescriptions, including refills, expire one year from the date they are written and sometimes sooner. Prior to the expiration of the prescription, you should obtain a new prescription from your doctor to provide to Medco.

Please allow two weeks for delivery from the date you mail your order. This allows time for delivery to and from the mail order pharmacy, plus internal processing time.

Coverage While Outside of the United States
If you will be traveling outside of the U.S. and you are covered by any of the UHC plans, your coverage is limited to medical emergencies. If you will be residing outside of the U.S. for longer than 30 days, you should contact WFMO to request enrollment in the international expatriate coverage. Our international coverage is through BUPA International.
Dental Plan Highlights
Good Dental care is an important part of your overall health. One of the most important things you can do is to receive regular dental treatment. The Dental plan offered by Tulane University is a Dental Preferred Provider Option (DPO) Dental plan through MetLife Dental that offers you and your family comprehensive coverage that helps pay for a broad range of dental services. You can use any licensed provider you want but your out-of-pocket expense will be less if you use a MetLife Preferred dentist because they have agreed to charge reduced fees. You will be charged no more than the fees approved by MetLife as the maximum plan allowance. If you use a non-Preferred Provider, you will be responsible for the dentist’s fees that may be higher than those approved by MetLife.

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$50 per person to $150</td>
</tr>
<tr>
<td></td>
<td>Per Calendar Year Maximum</td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>$1,500 Per Person Per Year</td>
</tr>
<tr>
<td>Orthodontia Lifetime Benefit</td>
<td>$1,500 Per Person Per Year</td>
</tr>
<tr>
<td>Preventive &amp; Diagnostic Services</td>
<td>100%</td>
</tr>
<tr>
<td>Cleanings, Oral Exams (No Deductible)</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Restorative Services</td>
<td>80%</td>
</tr>
<tr>
<td>Filings, Simple Extractions, Crown, Denture and Bridge Repair, Sealants</td>
<td>80%</td>
</tr>
<tr>
<td>Major Services</td>
<td>50%</td>
</tr>
<tr>
<td>Bridges and Dentures, Crowns Inlays/Onlays, Endodontic, General Anesthesia, Oral Surgery, Periodontics</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontia Services</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontia appliances and services for children up to age 19</td>
<td>50%</td>
</tr>
</tbody>
</table>

How the Dental Plan Works
To use your MetLife Preferred program, just call the dental office and verify that the dentist is a MetLife Preferred dentist. During your first appointment, give your dentist the primary enrollee’s social security number your and the group number listed in the back of this Guide. For a list of dentists in your area, search the dentist directory on their web site at www.metlifedental.com. Note that I.D. cards are not issued for the Dental plan.

Deductibles
For services other than Preventive & Diagnostic care, you and each of your eligible dependents must first pay a $50 annual deductible each year before any benefits will be paid by the plan. The family maximum deductible is $150 per year. Once you and your eligible family members have met the deductible, no other family members will have to satisfy a deductible during the year.

How the Plan Pays Benefits:
Preventive & Diagnostic Services
• 100 coverage, up to the annual maximum:
- Two cleanings and exams per calendar year, separated by a six-month period.
- One fluoride treatment per calendar year for dependent children up to 19\textsuperscript{th} birthday.
- Full mouth X-rays: one per 60 months.
- Bitewing X-rays: one set per calendar year for adults; two sets per calendar year for children under 19 years of age, separated by a six-month period.

### Basic Services
- 80% coverage, up to the annual maximum:
  - Amalgam fillings for all teeth or resin fillings for any non-molar teeth.
  - Extractions of non-impacted teeth.
  - Repair or re-cementing of crowns, inlays or onlays, or bridgework.
  - Oral surgery on permanent teeth.
  - Prefabricated stainless steel or prefabricated resin crown.
  - Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year.
  - Space Maintainers for dependent children up to 19\textsuperscript{th} birthday. One application of sealant material every 5 years for each non-restored, non-decayed 1\textsuperscript{st} and 2\textsuperscript{nd} molar of a dependent child up to 19\textsuperscript{th} birthday.

### Major Services
- 50% coverage, up to the annual maximum:
  - Denture repair and denture and bridgework replacement: one every 10 years.
  - Initial placement to replace one or more natural teeth, which are lost while covered by the Plan.
  - Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.
  - Replacement: once every 5 years to the same tooth surface.
  - Root canal treatment limited to once per tooth per 24 months.
  - When dentally necessary in connection with oral surgery, extractions or other covered dental services.
  - Scaling and root planing once per quadrant, every 24 months.
  - Periodontal surgery once per quadrant, every 36 months.
  - Relines and rebases of existing removable dentures, but not more than once in 36 months.
  - Fixed and removable appliances for correction of harmful habits.

Note: Expenses for the different types of services above are combined for the annual maximum.

### Orthodontia Services
- 50% coverage up to the Orthodontia Lifetime Maximum. Procedures performed by a dentist using appliances to treat poor alignment of teeth and/or jaws which significantly interferes with their function. Payment for orthodontics is provided monthly.

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**Want to Avoid Surprise Dental Bills?**

**Predetermination of Dental Benefits**

If you or one of your family members needs Basic, Major or Orthodontia services, you should request that your dentist or orthodontist file a “Predetermination of Dental Benefits” with MetLife. The Predetermination of Dental Benefits consists of a written description of the patient’s condition, including x-rays, the proposed form of treatment and the estimated treatment cost. MetLife will review the Predetermination of Dental Benefits and advise your dentist of the amount the Dental Plan will pay before treatment begins.
Usual, Customary and Reasonable (UCR) Charges
Charges for services will be considered “Usual, Customary and Reasonable“ (UCR) if they are comparable to the usual cost for corresponding treatment, services, or supplies for similar dental conditions in your geographic area, as determined by MetLife. MetLife Preferred Provider Dentists accept UCR as payment in full, (or their filed fees, whichever is less) less the patient’s portion of total charges.

Filing a Claim
If you use a MetLife Preferred Provider, the provider will file claims for you. For non-MetLife providers, the provider may accept partial payment from you and then file a claim for reimbursement on your behalf. To file a dental claim you should:

- Obtain a dental claim form from the WFMO web site before you plan to visit your dentist in the event that they are unable to file claims with MetLife electronically
- Complete the “employee” portion of the form
- Give the partially completed form to your dentist to complete the remaining sections
- You or your dentist should then send the completed form directly to the address shown on the claim form.
Vision Plan Highlights
Good eyesight is an important part of your everyday life. Tulane University offers you and your family a comprehensive Vision Care Plan through EyeMed that helps make vision care expenses more affordable. By encouraging regular vision exams and helping you pay for necessary corrective lenses and procedures, the vision plan helps you maintain your vision needs at a reasonable cost.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Member Cost and/or Allowance</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam (Once every 12 months)</td>
<td>$10</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Frames (Once every 24 months)</td>
<td>$0</td>
<td>Up to $80</td>
</tr>
<tr>
<td>Standard Plastic Lenses (Once every 12 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Single Vision</td>
<td>$20</td>
<td>Up to $40</td>
</tr>
<tr>
<td>• Bifocal</td>
<td></td>
<td>Up to $60</td>
</tr>
<tr>
<td>• Trifocal</td>
<td></td>
<td>Up to $90</td>
</tr>
<tr>
<td>• Lenticular</td>
<td></td>
<td>Up to $90</td>
</tr>
<tr>
<td>Contact Lenses - Elective</td>
<td>$0</td>
<td>Up to $105 Allowance</td>
</tr>
<tr>
<td>Contact Lenses - Medically Necessary</td>
<td>Paid in Full</td>
<td>Up to $200</td>
</tr>
</tbody>
</table>

How the Vision Plan Works
The vision plan reimburses you for covered expenses you pay for eye care. Two schedules of benefits apply: one for care received through the EyeMed network of providers, and one for non-network providers as illustrated above.

The vision plan covers:
• Vision Exams
• Lenses
• Frames
• Contact Lenses

Give the person assisting your I.D. card and tell them that you are a member of an EyeMed Vision Plan. The provider will call EyeMed Member Services for verification of eligibility, receive an authorization number, and provide services. The provider handles all claims for in-network services. You pay your copayment, plus any charges over and above (or not covered) by the Plan.

Only Need an Exam?
UnitedHealthcare Vision Coverage
If you or one of your family members only need a vision exam and you are enrolled in one of our Medical plans, keep in mind that one exam per year is available for a $25 copayment. UHC also has a network of vision providers that you can use to access discounts on eyewear. Note that no other routine vision-related services or supplies are available under the Medical Plans.
**Long-Term Disability Plan Highlights**

The Long-Term Disability (LTD) Plan is designed to continue a portion of your earnings during extended periods of total disability as a result of an on or off-the job injury or illness. Your benefit will be based on 66 2/3% of your monthly base earnings, which excludes over-time and any other special payments. The minimum monthly benefit is 10% of your monthly benefit or $100, whichever is greater. The maximum monthly covered earnings is up to $8,000.

**How the LTD Plan Works**

**When Benefits Begin**

Your benefits under this Plan are eligible to begin after you have been disabled for 90 consecutive days (the Elimination Period). You must also be under a physician’s continuing care during the time you are disabled. All benefits are paid on a monthly basis. Your first LTD payment will be sent at the end of the first 30 days after completing the Elimination Period. Ongoing payments will be paid at the end of each 30-day period (in arrears) while you continue to be disabled.

**Definition of Disability**

For the benefit waiting period and the first 60 months for which LTD benefits are paid, being unable as a result of physical disease, injury, pregnancy or mental disorder, to either:

- Perform with reasonable continuity the material duties of the employee’s own occupation; or
- Earn 80 percent or more of pre-disability earnings in the employee’s own occupation.

After that, being unable as a result of physical disease, injury, pregnancy or mental disorder to perform with reasonable continuity the material duties of any gainful occupation which:

- The employee is able to perform, due to education, training or experience,
- The employee can be expected to earn at least 80 percent of pre-disability earnings within 12 months of returning to work, regardless of whether the employee is working in any other occupation.

The employee is not disabled when earning 80 percent or more of pre-disability earnings in any occupation.

**When A Disability Will Be Considered A New Period of Disability**

If, after receiving a monthly benefit under this Plan, you resume all of the material duties of your regular or any occupation on an uninterrupted full-time basis for more than 90 days and again become disabled by the same or related sickness or injury, your disability will be considered a new period of disability. If, after receiving a monthly benefit under this Plan, you resume all of the material duties of your regular or any occupation on an uninterrupted full-time basis and again become disabled but your disability is due to a sickness or injury that is unrelated to the cause of your prior period of disability, your disability will be considered a new period of disability. You must complete a new elimination period in either case.
Monthly Annuity Premium Benefit
If you meet the requirements specified in the group policy, a monthly annuity premium benefit may be payable to the administrator of your 403(b) retirement plan as premiums remitted on your behalf under the terms of your employer’s retirement plan. The amount of the monthly annuity premium benefit will be a percentage of your pre-disability earnings. Additional details on this benefit can be found in the certificate of coverage.

Reduction of Plan Benefits
Your benefits from this Plan will be reduced by any benefits that you are eligible to receive from other sources such as Workers’ Compensation, Social Security (any benefit due you and your family), or any other federal or state government or employer-sponsored plans. Once payments under this Plan have started, your benefit will not be reduced by any increase in Social Security benefits or other cost-of-living adjustments. Keep in mind that your benefits will be reduced if you are eligible for other benefits, like Social Security, whether or not you actually apply for benefits. That is why it is important that you apply for benefits as soon as possible. Of course, if you supply proof that you have applied for those benefits and were denied payment, this offset will not apply.

Maximum Benefit Period
If an employee becomes disabled before age 60, LTD benefits may continue until age 65. If an employee becomes disabled at age 60 or older, the benefit duration is determined by the age when disability begins:

<table>
<thead>
<tr>
<th>Age on Date of Disability</th>
<th>Maximum Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 through 64</td>
<td>4 years 9 months</td>
</tr>
<tr>
<td>65 through 68 and 9 months</td>
<td>to age 70</td>
</tr>
<tr>
<td>68 and 9 months or older</td>
<td>1 year</td>
</tr>
</tbody>
</table>

Mental Health & Substance Abuse Limitations
There is a 24-month lifetime limitation for some mental or nervous disorders. Not all mental and nervous claims are subject to this limitation. There is also 24-month lifetime limitation (while benefits are payable) for disabilities due to substance abuse. Benefits payable are limited to one period of disability during the employee’s lifetime.

Rehabilitation Employment While Receiving Long-Term Disability Benefits
If you are totally disabled, you may consider opportunities for rehabilitation employment without jeopardizing your LTD benefits. Rehabilitation employment refers to any program of work designed to allow disabled employees to learn new skills or improve their current skills in order to make the best use of their abilities.

Pre-existing Condition Exclusion
Benefits are not provided for any disability caused by a pre-existing condition. A pre-existing condition refers to an injury, sickness, or pregnancy for which the disabled person consulted with a licensed medical practitioner or received any treatment within three months before the effective date of participation in the Plan. If this happened, you will not receive benefits for the first 12 months of coverage if it is caused by, contributed to, or resulted from a pre-existing condition.

What Happens if I Die While on LTD?
Three-Month Survivor Benefit
If you die after having received LTD benefits for six months, your beneficiary will receive three times the gross monthly benefit being paid at the time of your death.
Life and Accidental Death & Dismemberment Plan Highlights

The University provides 1.5 times annual salary in basic life insurance to a maximum of $50,000. The University also purchases basic dependent life insurance in the amount of $2,000 for your spouse and each dependent child. Tulane also offers supplemental life and AD&D coverage. You can purchase one half to 5 times your annual salary. You can elect up to $150,000 life insurance for your spouse or SGDP and up to $20,000 for each child.

Voluntary AD&D pays a benefit to you or your designated beneficiary in the event of an accident resulting in the death of or certain dismembering injuries to the covered person. You may elect up to $500,000 Voluntary AD&D coverage, and dependent coverage is a percentage of your election.

The University provides Business Travel Accident coverage at no cost to you. This plan pays a $100,000 benefit to your designated beneficiary in the event of a business travel-related accident resulting in death, or a portion this amount in the event of dismembering injuries.

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Benefit Schedule</th>
<th>Cost Paid By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Employee Life Insurance</td>
<td>1.5 X Annual Salary to $50,000</td>
<td>Tulane</td>
</tr>
<tr>
<td>Basic Spouse Life Insurance</td>
<td>$2,000</td>
<td>Tulane</td>
</tr>
<tr>
<td>Basic Child Life Insurance</td>
<td>$2,000</td>
<td>Tulane</td>
</tr>
<tr>
<td>Supplemental Employee Life Insurance</td>
<td>One Half to 5 X Annual Salary to $500,000</td>
<td>You</td>
</tr>
<tr>
<td>Spouse Life Insurance</td>
<td>$10,000 Increments to $150,000</td>
<td>You</td>
</tr>
<tr>
<td>Child Life Insurance</td>
<td>$10,000 or $20,000</td>
<td>You</td>
</tr>
<tr>
<td>Employee Voluntary AD&amp;D Insurance</td>
<td>$10,000 Increments to $500,000</td>
<td>You</td>
</tr>
<tr>
<td>Dependent Voluntary AD&amp;D Insurance</td>
<td>Spouse Only, Child Only and Family Coverage Options</td>
<td>You</td>
</tr>
<tr>
<td>Tulane Death Benefit</td>
<td>One Month’s Gross Salary</td>
<td>Tulane</td>
</tr>
<tr>
<td>Business Travel Accident Insurance</td>
<td>$100,000</td>
<td>Tulane</td>
</tr>
</tbody>
</table>

How the Life and AD&D Plans Work

Life Insurance

Your named beneficiary (ies) will receive the Life Insurance Death Benefit in the event of your death, subject to the exclusions in the insurance contract.

Voluntary Accidental Death & Dismemberment

Your named beneficiary (ies) will also receive the full AD&D benefit in addition to the life insurance benefit in the event of your accidental death. The AD&D benefit is in addition to the Life Insurance Benefit and is based on AD&D Benefit Schedule in the certificate of coverage.

Waiver of Premium During Disability

If you become totally disabled before age 60 and while insured, your life insurance coverage will continue as long as you remain disabled without further payment of premium, until you reach age 65.
The first proof of disability must be provided to the insurance company no later than 270 days after the date of disability. The insurance company may require you to be examined by a physician of its choice, and other conditions may apply.

Medical History Statement
You will not be required to answer any health questions or otherwise provide any “Evidence of Insurability” (EOI) to be covered under the Basic Life and AD&D Plans. However, EOI will be required under the following circumstances:
- Supplemental Employee Life Insurance: You elect an amount that is in excess of 3 times your annual salary or $500,000, whichever is less
- Spouse Life Insurance: You elect an amount in excess of $20,000
- Child Life Insurance: You elect $20,000
- You apply for supplemental employee, spouse and dependent life insurance after initially declining coverage

Naming a Beneficiary
Your beneficiary is the person you choose to receive the proceeds of your Life and AD&D insurance if you die. To name a beneficiary, you should complete the beneficiary designation section of the Benefits Enrollment/Change Form available on the WFMO web site. If you want to change your beneficiary designations, you can do so by filling out this same form. You can name more than one beneficiary and indicate what percentage of your benefit each beneficiary will receive. Remember to keep your beneficiary designations up to date. If you have a Status Change (i.e. marriage, divorce, birth of a child) you may want to consider updating your designations.

Payment of Benefits
Insurance benefits are payable when the insurance company receives proof of your death. Benefits are usually paid in a lump sum if the total benefits are less than $25,000. If the total benefits payable Life and AD&D insurance benefits are paid to your beneficiary (ies). You should inform your beneficiary (ies) to contact WFMO in the event of your death.

The plan also has a provision that provides for the beneficiary(ies) to “assign” all or a portion of the benefits payable to a funeral home, cemetery or other funeral service provider. You or your beneficiary should contact WFMO in the event assistance with funeral expenses is needed.

Conversion of Life Insurance
If your Life Insurance coverage ends because your employment, eligibility or the Plan terminates, you may be able to convert your group policy to individual coverage. The converted policy would be continued at your expense, and you must apply within 31 days of the date your Tulane coverage ends. The amount that you can convert is limited to the amount of Basic Life coverage you had on the date of your termination.

Portability of Life Insurance
If your Supplemental Life Insurance coverage ends because your employment or eligibility terminates, you may be able to “port” (or “take with you”) your supplemental coverage’s to individual Term Life and AD&D policy(ies). The ported policy would be continued at your expense, and you must apply within 31 days of the date your Tulane coverage ends. You have the option to port any amount up to the amount of coverage in effect for you and your dependents at the time of your termination of employment or are no longer eligible.

Accelerated Death Benefit for Employee Supplemental Life
The Accelerated Death Benefit feature allows you to receive up to 75% of your life insurance benefit (to a maximum of $500,000) while you are still living. You must be diagnosed with a condition that is expected to result in death within 12 months. Other conditions also apply.
Electing Spouse Life Insurance
Please note that if you may not elect Spouse life insurance if your spouse or Domestic Partner is a benefits-eligible employee of Tulane University; however, you may both elect Supplemental Life and name each other as beneficiaries.

Benefit Reduction
If you die while an active employee and after you are age 70, your benefit will be reduced as follows.

<table>
<thead>
<tr>
<th>At Age</th>
<th>Benefit Reduces</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>65%</td>
</tr>
<tr>
<td>75</td>
<td>45%</td>
</tr>
<tr>
<td>80</td>
<td>30%</td>
</tr>
</tbody>
</table>

University Death Benefit
This plan provides that in the event of your death while an active, eligible and compensated employee, the University will pay to your beneficiary an amount equal to one month’s base salary. This is in addition to the payment of your regular salary and vacation pay out. This benefit is provided at no cost to you.

Business Travel Accident Insurance
Your named beneficiary (ies) will also receive Business Travel Accident benefit of $100,000 in the event of your accidental death while traveling on Tulane University business. If you experience dismemberment, the benefit is based on AD&D Benefit Schedule located in the certificate of coverage. This benefit is provided at no cost to you.
Flexible Spending Account Plan (FSA) Highlights

These accounts are designed to give you a tax-free way to pay for healthcare and dependent care expenses that you would normally pay for on an after-tax basis.

<table>
<thead>
<tr>
<th>Flexible Spending Account</th>
<th>Purpose</th>
<th>Maximum Annual Election</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Flexible Spending Account</td>
<td>Reimburse you for eligible, out-of-pocket medical, dental and vision expenses for you and your qualified dependents up to the amount of your annual contribution</td>
<td>$4,800</td>
</tr>
<tr>
<td>Dependent Care Flexible Spending Account</td>
<td>Reimburses you for qualified child and adult care incurred so that you (and if married, your spouse) can work, and not claimed on your income tax return</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

How Flexible Spending Accounts Work

- You estimate your healthcare and/or dependent care expenses for the coming year and enroll in either or both accounts.
- Your contributions are made through payroll deduction before federal, FICA (and most cases state) taxes are withheld. This reduces your taxable income.
- Throughout the year, when you pay an eligible expense (such as a medical or day care bill), you submit a claim for reimbursement from your account. You also have the option of using the Benny™ Debit Card for the HCFSA.
- You are reimbursed with the money you set aside in your account.

How Much You Can Contribute

The maximum amount you can contribute is:

- $4,800 per year to a Healthcare Spending Account
- $5,000 per year to a Dependent Care Spending Account.

Your contributions are credited to your FSA account(s) each pay period.

**Note:** You must re-enroll each year during the open enrollment period to participate for the next year; your elections are not carried over from year to year.

IRS Regulations

The Flexible Spending Accounts can help you save money on taxes, but you have to estimate your expenses carefully because of these IRS limitations:

- You cannot transfer money from one account to another.
- You will forfeit any unused money in your account if:
  - Your eligible expenses for the year are less than your total annual contribution
  - You terminate employment during the year and your expenses are less than the amount you contributed before your termination.

To avoid this, you should reduce your contributions from your initial estimates.
Flexible Spending Accounts and Your Taxes
Since your payroll deductions for Flexible Spending Accounts take place before taxes are withheld, the amount you contribute will not be reported as taxable income to the IRS. That means your taxable income is lower, and you will pay less in taxes. Also, the amount of your contribution is not subject to Social Security taxes. Current tax law allows you to take a tax credit on certain healthcare and dependent care expenses when you file your federal income tax return. If you pay for these expenses with a Flexible Spending Account, you cannot deduct the same expenses on your income tax return.

How Much Can You Save?
The average person avoids taxation at approximately $300 per $1,000 of pre-tax deductions.

If you participate in the Dependent Care Spending Account, your contributions for the calendar will be indicated in Box 12 of your W-2 Form. It is necessary that you file an informational filing with the IRS (Form 2441) with your annual tax return. This is an additional filing that does not cause your pre-tax contributions under this Plan to be taxed.

If you had expenses not reimbursed through the Dependent Care Spending Account, you may be able to claim a tax credit on the IRS Form 2441. You should check with a tax advisor about these issues to make sure that Flexible Spending Account participation is right for you.

Healthcare Flexible Spending Account
Eligible Expenses
You can use your Healthcare Flexible Spending Account (HCFSA) to reimburse your eligible, out-of-pocket healthcare expenses during the calendar year up to the amount of your annual contribution. Generally, any healthcare expense that can be deducted from your federal income tax return can be reimbursed from your account. Remember, though, that you cannot be reimbursed through your account and take a deduction on your income tax return for the same expense.

Here are some examples of the types of expenses that are eligible for reimbursement from your HCFSA:

- Deductibles, coinsurance or copayments from medical, dental and vision care plans
- Expenses over the Plan maximums or non-covered services
- Prescription contact lenses and glasses.

These are just a few examples of the expenses eligible for reimbursement through your HCFSA. A complete list of qualified expenses is provided on the WFMO web site.

Ineligible Expenses
Not every healthcare expense you pay is reimbursable through the HCFSA. Below are some examples of the types of expenses that are not reimbursable through your account:

- Insurance premiums, including COBRA payments
- Expenses that have been paid by or are eligible to be paid by any other insurance, policy or government program (Medicare, for example)
- Cosmetic surgery, unless it is to correct an injury caused by disease or accident or to correct a birth defect
- Cosmetic procedures like bleaching of teeth
- Fees for health clubs, including spas and gyms
- Fees for weight-loss or smoking-cessation programs, unless they are prescribed by your doctor to treat a specific illness (not for general health improvement).
Benny Card for the Healthcare FSA

The Benny™ Debit Card is a debit card you can use for qualified medical, dental and vision expenses. You can use this card at any health care merchant who accepts MasterCard® and is an IIAS participating merchant. Because the Benny™ Debit Card pays your providers directly, you don’t have to wait for reimbursement. Each time you swipe the card your HCFSA is electronically debited. Note that you do not have to use the Benny card.

Claims Substantiation

According to IRS regulations you must still substantiate certain expenses. We have made it simple for you to comply with this requirement. When a charge needs to be substantiated, you will receive, via email, a Benny™ Card Documentation form designed specifically for your Benny™ Card swipes. This form is pre-populated with your service date(s) and transaction amount(s). It is emailed to you at the beginning of the month following the swipes requiring substantiation. Simply sign the form and return it to Benefit Concepts with the accompanying documentation showing the date, type, and cost of service.

You have up to the end of the month in which you receive the Benny™ Card Documentation form - plus a five (5) day grace period - to submit your form with the necessary documentation. Benny™ Debit Card transactions that have not been substantiated by the deadline will result in the temporary suspension of your card. Your card will be reactivated once all outstanding transactions have been substantiated.

You have two options if you have lost your receipts or have used the card for an ineligible expense:

- Write a check to Tulane University in the amount of the expense to reimburse the plan
- Submit additional claims to substitute the lost or unsubstantiated expense. Indicate on the claim form the intent to substitute claims for outstanding card charges

If you do not repay the plan or substitute future claims against the amount of the ineligible expense, Tulane may withhold the improper payment amount from your wages consistent with applicable federal and state law.

Plan Year Grace Period and the Benny Card

The card will only debit from your current year election. You must submit manual claims to draw down the prior year balance when making purchases during the grace period that follows each plan year.

Valid Merchants

The card is accepted at any IIAS participating merchant and health care merchants using the MasterCard® system. This includes:

- Doctor Offices
- Dental and Vision offices
- Hospitals
- Mail Order Prescription Programs

A card transaction can be denied at a merchant for several possible reasons:

- The card is suspended due to a prior transaction
- The card has not been activated
- The card swipe is more than the available HCFSA balance
- The purchase is being made at a merchant that is not an approved vendor

You can view a list of participating pharmacies by going to www.benefitconcepts.com.
**Dependent Care Flexible Spending Account**

You can use your Dependent Care Flexible Spending Account (DCFSA) to pay for work-related dependent care expenses with tax-free dollars. Dependent care is only care that is provided so that you can work. If you are married, you can use this account if your spouse is:

- Working or looking for work
- A full-time student for at least five months each year
- Mentally or physically handicapped and unable to care for a dependent.

**Restrictions for Married Participants**

If you are married and your spouse also participates in a dependent care account, there are some additional restrictions:

- You and your spouse cannot contribute more than $5,000 per year combined.
- If you or your spouse earns less than $5,000, you cannot contribute more than the amount of the lower-paid spouse’s annual income. For example, if your spouse earns $4,500 per year, your combined contributions cannot be more than $4,500.
- If you and your spouse file your taxes separately, each of you cannot contribute more than $2,500. If your spouse is a full-time student for at least five months of the year or is disabled, you can contribute a maximum of:
  - $2,400 for one dependent
  - $4,800 for two or more dependents.

**Eligible Expenses**

These are the types of expenses that are eligible for reimbursement from your DCFSA:

- Wages paid to baby-sitters or companions in or out of your home so that you can work; please note that the wages you pay must be reported to the IRS by the person who receives them
- Wages paid to housekeepers who are also responsible for dependent care
- Charges for care provided by licensed day care centers (does not include registration and other fees)
- Charges for care provided for a disabled dependent by a licensed care center as long as your dependent lives with you at least eight hours per day (does not include registration and other fees)
- Federal taxes that you pay on behalf of dependent care providers.

**Ineligible Expenses**

Not all expenses related to care for dependents are reimbursable. Below are some examples of the types of expenses that are not reimbursable through your Dependent Care Spending Account:

- Care provided by your spouse
- Care that your spouse could provide if his or her work hours differ from yours
- Charges for overnight camps
- Payments to your child or stepchild who is under age 19 at the end of the tax year
- Payments to someone who could be claimed as a dependent on your or your spouse’s tax return
- Services that are provided at no cost or that are paid by another organization
- Transportation expenses
- Adoption agency charges
- Charges or tuition for kindergarten or education
- Entertainment, clothing or food charges
- Day care expenses for a period of time when you are away from work due to an illness or leave of absence.
- Charges for a period of time when you were not a participant in the DCFSA
- Expenses for a dependent during any time when you cannot claim the dependent for income tax purposes.
Filing Claims
An eligible expense must be for services that were incurred during the calendar year and while you were contributing to your account. For the HCFS, you have a 2 ½ month grace period if you have not used all of the funds in your HCFS. In other words, you have from January 1 through March 15 of the following year to incur expenses for the HCFS.

If you start contributing to an account during the year (for example, you are a new hire), the expense must be for a service received after you started participating in the HCFS and DCFSA.

You will have until April 30 of the following year to submit expenses for reimbursement. However, any balance remaining in either one of (or both) accounts after April 30 will be forfeited.

Documentation Requirements for Paper and On-line HCFS Expense claims:
- For medical or dental expenses that will be processed under insurance plans, please submit the expenses to your insurance carrier first, and then submit a copy of the Explanation of Benefits (EOB) with the claim form. Proof of payment of the expense is not required.
- If you do not have insurance coverage for certain expenses, submit an itemized statement the provider showing the patient name, name and address of the provider, date of service, description of service and amount of charge.
- For orthodontia expenses, please submit a copy of the contract or treatment plan with your initial submission itemizing the treatment period, down payment and amount of monthly payments, and the amount covered by insurance, if any. Submit a copy of your monthly payment coupon and/or itemized receipt each time you request reimbursement for ongoing treatment. Note: the plan cannot reimburse for future service or for the portion of treatment occurring in another plan year unless a lump sum is paid for the full cost of the treatment at the beginning of treatment.
- For Rx and Over-the-Counter (OTC) Drug co-payments, submit a copy of the Rx co-payment receipt showing the patient name, name of the drug, date the Rx was filled, and co-payment amount. For OTC drug reimbursement, submit a copy of your cash register receipt detailing the name of the OTC drug, date purchased and amount. If the cash register receipt does not specify the name of the OTC drug, submit a tear-off portion of the box or package that includes the name and price, and submit along with the cash register receipt.

Documentation requirements for Dependent Care Expense Reimbursement
- Submit a receipt or statement from your day care provider showing the “from/through” dates of service description of the charge (i.e., child care or preschool) and the amount of the charge. Proof of payment is not required. You may have your provider sign the receipt at the bottom of this form each time you request reimbursement.
- Your claim cannot be processed until after the services have actually been rendered. For example, if you pay your child care weekly on a Monday for that week, you should submit your claim on Friday after the services have been rendered. If you pay your child care expenses on a monthly basis, you will need to wait until the last day of the month to submit for reimbursement.
- You must provide the IRS with the name, address and Tax I.D. (or Soc. Sec. No.) of the dependent care provider. If you are unable to provide this information, the DCFSA claim will be denied.
**Tulane Pre-Tax Parking Deduction Highlights**

The Tulane Pre-Tax Parking Deduction Plan allows you to pay for Tulane parking permit or monthly contract with pre-tax dollars. This pre-tax benefit is available only through payroll deduction for qualified parking as defined by the IRS and established by your campus (e.g., Tulane owned, leased or contracted parking facility). Deductions are taken from your pay before federal, state, Social Security, and Medicare taxes are calculated. Your taxable income is reduced, and consequently, your taxable income reflected on your annual W-2 statement is reduced. The Tulane Pre-Tax Parking Deduction will have no impact on your retirement or on any other Tulane-paid benefit. However, depending on your salary, your Social Security benefits at retirement may be reduced slightly, because you will have paid Social Security taxes on a lower wage.

**How the Pre-tax Parking Works**

Pre-tax deductions to pay for your parking permit or monthly contract will be effective the month following completion and submission of your deduction authorization form. Your participation will continue from pay period to pay period until you terminate participation or separate from Tulane employment. If you choose to participate or want to make a change, you must contact either the Public Safety Office (for Uptown employees) or the Parking Services office (for Downtown and Medical Center parking) to purchase the parking permit or monthly contract.

**Eligible Expenses**

The IRS limits qualified parking expenses to parking at or near your work location or at a location from which you commute to work by carpool. The Tulane arrangement allows a pre-tax benefit only for qualified parking paid by you through payroll deduction.

**Amount You Can Contribute**

For 2010, IRS Code Section 132(f) limits the amount of qualified parking that may be excluded from your taxable income to $220 per month for a pre-tax parking deduction. The parking pass fee deduction schedule is usually less than this amount. Any amount of parking deduction in excess of $220 will be paid with after-tax dollars.
Tulane Retirement Plan Highlights

The Tulane 403(b) plan is designed to help you save for your retirement years. The Tulane 403(b) plan consists of the Faculty & Administrative Officers Retirement Plan and the Tax Deferred Annuity Plan. If eligible, you may also participate in the 457(b) Deferred Compensation plan as an additional savings source. You have the opportunity to design your own retirement program with one of two investment companies that offer a broad array of investment choices.

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How the 403(b) Plans Work

Eligibility

Faculty & Administrative Officer Retirement Plan

You are eligible to participate after two years of eligible employment (having worked no less than 975 hours in each of the two consecutive years) but exclude medical residents, employees whose employment is incidental to their educational program at the University (Post Doctoral Fellows) and those who are eligible for participation in the Staff Retirement Plan.

403(b) Tax-Deferral Plan

All employees are eligible to participate immediately upon hire or re-hire.
Contributions to the Plans
The University contributes an amount equal to 8.00% of your salary (if your annual salary is less than $80,000) or 10% (if your annual salary is greater than $80,000). You are eligible to participate after two years of full-time employment. You will be required to defer at least 2% of your salary if your annual salary is greater than $80,000. Plan participants also investment options to choose from through Fidelity Investments and TIAA-CREF.

Regular Salary is your basic earnings, exclusive of overtime, bonuses and other forms of additional compensation. Regular salary is determined before any reduction under the Tulane Tax-Deferral Plan or the University’s Flexible Spending or Medical, Dental and/or Vision plan deductions that are taken on a pre-tax basis.

For the TDA plan, you can contribute up to the IRS limit of $16,500 to each plan during 2010. You defer paying taxes on any earnings that accumulate in your account until you take a distribution.

How to Enroll
To participate in the TDA and Retirement plans, an eligible employee must complete log into the applicable investment company web site to open an account. If you are enrolling in the TDA plan, you must complete return to the University the appropriate Salary Reduction Agreement (SRA) for Fidelity Investments or TIAA-CREF. Participation in this plan will begin on the first day of the next payroll period following receipt of the appropriate enrollment forms, which can be found on the WFMO web site.

To enroll in the TDA and/or Retirement plans, an employee must complete both (i) an approved vendor’s online application to open an account, and if you are enrolling in the TDA plan (ii) an SRA to elect the contribution amount according to the instructions below. Your contribution must be expressed as a flat dollar amount and not a percentage of salary. The SRA will apply only to amounts earned after enrolling in the Plan, and an employee's election under the SRA will continue until the SRA is modified or revoked by the employee. The SRA for each approved vendor is on the WFMO web site.

Ownership of Employer and Employee Contributions
You are always 100% vested in employee and University contributions made to the Retirement and Tax Deferred Annuity plans.

To enroll with Fidelity:
1. Go to http://enrollonline.fidelity.com
2. Type in the plan's identification number (54695 for the TDA plan, 84783 for the Faculty & Administrative Officers Retirement plan) and your Social Security number
3. Follow the prompts to create a customer number (other than your Social Security number) and PIN
4. Go to www.netbenefits.fidelity.com and select "Beneficiaries" in the "My Profile" section.
5. Designate your beneficiary(ies) for your 403(b) account at Fidelity and receive instant online confirmation
6. Fax your completed SRA to Workforce Management at (504) 865-6727 to the attention of Benefits.

If you are having any problems with the website, please call (800) 343-0860.

To enroll with TIAA-CREF:
1. Go to http://enroll.tiaa-cref.org/tulane
2. In the upper right corner, click Enroll Now
3. Select Tulane University Tax Deferred Plan (or Faculty & Administrative Officers Retirement Plan) in the middle of the bottom of the page.
4. Type in access code LA100222 if you are enrolling in the TDA plan, or access code LA100220 if you are enrolling in the Staff Retirement plan.
5. Click No to the question, “has a TIAA-CREF consultant solicited this application from you” then follow the prompts to complete the enrollment.
6. Fax your completed SRA to Workforce Management at (504) 865-6727 to the attention of Benefits.
7. If you are having any problems with the website, please call (877) 518-9161.

Investing Your Accounts
To help you grow your 403(b) account over time, you can invest your account balances with either Fidelity Investments or TIAA/CREF. More information about investing can be found on the WFMO web site.

In general, you direct how your contributions are invested on your application to Fidelity Investments or TIAA-CREF. You may only designate either Fidelity Investments or TIAA-CREF to receive University contributions, but not both at the same time. However, you may designate TDA contributions to the other company. For example, you may designate TIAA-CREF to receive University contributions and Fidelity to receive your TDA contributions.

You can divide your contribution between investments within either company in any whole-number percentages. Once you are participating in the plan, you can change the division of your future contributions at any time by contacting Fidelity or TIAA-CREF directly. You will receive quarterly statements showing your accumulation of funds.

To assist you in determining how you should invest your funds, tools and assistance are provided on both the Fidelity and TIAA-CREF web sites. Tulane also hosts periodic meeting where you can meet individually with an advisor. WFMO distributes announcements of upcoming meetings.

Basics of Investing
The world of investing is laden with its own terminology. To help you understand this better, below are some of the key terms and concepts associated with investing:

Annuities
In general, an annuity is a contract by which an insurance company agrees to make regular payments during retirement. A fixed annuity guarantees principal and a specified interest rate, and may also offer additional amounts based on the claims-paying ability of the issuing company. A variable annuity does not make any guarantees.

The returns and value of a variable annuity account will fluctuate based on the investment performance of the underlying securities in its portfolio. For the purposes of your retirement plan, the main difference between variable annuities and mutual funds is that a mutual fund cannot be used for receiving income in the same manner as an annuity. However, mutual funds offer more focused investment styles than annuities, offering you the ability to choose the funds that correspond closely to your more specific investment objectives. Annuities may also restrict the amount that you can withdraw.

Asset allocation
The way you choose your investment mix is the foundation of your portfolio's performance. The goal of asset allocation is to create the most efficient mix of investments or asset classes that have the potential to appreciate while meeting your tolerance for risk or market volatility.
Averages and Indices
These are statistical tools that measure the state of the stock market or the economy, based on the performance of stocks, bonds or other components. The Dow Jones Industrial Average and the S&P 500 Index are well-known examples.

Bonds
An investment that pays interest in installments until a future maturity date, when the issuing government or company repays the bond’s face value.

Diversification
The key to smart asset allocation — and one of the best ways to manage risk — is to diversify, or "spread the risk" over a variety of investments. Since different types of investments may perform better than others at different times, diversification can help you offset the volatility (and potential losses) of a single investment and take greater advantage of the strengths of several asset classes working together.

Dow Jones Industrial Average
A popular gauge of the stock market based on the average closing prices of active representative stocks, as published by Dow Jones & Company. The “Dow” or “DJIA” is the best known barometer of the market for shares of the largest US companies.

Equities
An investment category, Equities (stocks), which represent shares of ownership in companies, have historically outperformed other investments over long periods. They have also tended to be the most volatile in the short term, which means investors may experience fluctuating account values.

Expense Ratio
A mutual fund’s cost of doing business, disclosed in the prospectus as a percent of assets. The ratio includes expenses such as management and advisory fees, overhead costs, distribution and advertising fees.

Financial Planning
A process in which an individual sets long-term financial goals through investments, tax planning, asset allocation, risk management, retirement planning and estate planning.

Fixed-Income
This category of investments includes bonds and securities that are designed to pay a rate of interest over a set time period and then return the investor’s principal. The value of fixed-income investments fluctuates in response to interest and inflation rates.

Fund Family
A set of mutual funds, with different investment objectives, managed and distributed by the same company. In many cases, investors may move their assets from one fund to another within the family at little or no cost.

Lifecycle Funds
Ready-made diversified portfolio options comprising "funds of funds", they seek high total return over time through a combination of capital appreciation and income.
Money Market
This asset class consists of short-term debt instruments and government securities which carry little risk. They generally pay more interest than savings accounts or CDs, but historically their returns have been lower than those of stocks and bonds.

Mutual Fund
A fund operated by an investment company that pools money from many people to invest in various types of securities. Funds can impose a sales charge, or load, on investors when they buy or sell shares. Some are no load and impose no sales charge. Mutual funds offer investors a variety of investment strategies or objectives, depending on the pool of money and its investment charter. Each fund’s objective is stated in its prospectus.

Other Savings and Investments
It’s important to coordinate the decisions you make about your retirement plan allocations with any other assets you’re likely to have during retirement (such as Social Security benefits, personal savings or IRAs). All of these savings will need to work together to produce the retirement income you’re looking for.

Portfolio
The entire combination of securities or investments an individual or institution holds. A portfolio can contain a variety of government and company bonds, preferred and common stocks from different businesses and other types of securities and assets.

Prospectus
A prospectus commonly provides investors with material information about mutual funds, stocks, bonds and other investments, such as a description of the company’s business, financial statements, biographies of officers and directors, detailed information about their compensation, any litigation that is taking place, a list of material properties and any other material information.

Risk and Return
At the cornerstone of any savings or investment plan is the relationship between risk and return. As a rule, the potential return on any investment corresponds to its level of risk.

S&P 500 Index
Standard and Poor’s 500 Index is a performance gauge that covers 500 industrial, utility, transportation, and financial companies of the US markets, mostly on the New York Stock Exchange.

Time Horizon
Time Horizon is the time span of your investment objectives. Your time horizon dictates the types of investments that are suitable for your portfolio.

Rebalancing
It’s a good idea to revisit your investment mix periodically, as your goals, investment time horizon and personal situation change.
Receiving Your Benefits

Generally, you will begin to receiving your distributions from the 403(b) plan when you retire. You will pay income tax on the taxable portion of your benefit as you receive it. Because the goal is to save money for retirement, there are restrictions on when you can receive your benefits. Apart from certain qualifying circumstances, after terminating your employment with the University, an early withdrawal of your money, which is prior to age 59 ½, may be subject to a 10% tax in addition to your regular income tax.

If you die before starting to receive benefits, your beneficiary is entitled to the full current value of your benefit accumulation. There are certain rules and restrictions about choosing a beneficiary other than a spouse.

You may also ask to have part of your total benefit paid in one lump sum. If you are married, your spouse will need to consent to this type of distribution.

You have several options for receiving your Fidelity and/or TIAA-CREF benefit payments. You may choose different methods of payment from each company. In addition, under certain circumstances, you may be required to begin the receipt of benefits.

How the 457(b) Plan Works

This plan gives eligible employees an additional opportunity to defer compensation, above the limits for the University 403(b) plan, as defined by the Internal Revenue Code. To be eligible, you must have earned in the prior calendar year (or expected to earn in the current calendar year) $150,000 or more as reported on the employee’s Form W-2. This $150,000 minimum may increase from time to time in the future as Internal Revenue Service limits changes limits. This plan is only available through TIAA-CREF.

Contributions

The Internal Revenue Code requires that all of your contributions be considered to be owned by the University and as such are subject to claims of University’s creditors in the event of Tulane’s bankruptcy. The maximum that you can contribute is generally the same as the Tax Deferred Annuity. For 2010, you can contribute up to the IRS limit of $16,500.

Distributions

A participant may not receive any in-service distribution of their accumulated funds and must start distribution of benefits within sixty days following severance from employment. Alternatively, you may make an additional one-time written election to defer commencement of benefits to a later date. If a participant fails to make an election during the sixty-day period following severance from employment, the participant will receive a lump sum distribution within ninety days following severance from employment. Distribution options include:

- Lump sum or
- Installment payments (monthly, quarterly, semi-annual, or annual),
- Annuity Income

How to Enroll

To participate in this plan, an eligible employee must complete and return to the University the TIAA-CREF Voluntary Salary Deferral form. Participation in this plan will begin on the first day of the next payroll period following receipt of this form, which can be found on the WFMO web site.
Employee Assistance Plan Highlights

Administered through Horizon Health, Tulane University provides an Employee Assistance Plan (EAP) to help provide counseling, therapy, and rehabilitation to all members of your household who have personal or family behavioral health concerns. This can include information on a wide range of issues: family matters, psychosocial child rearing concerns, substance abuse, financial problems and mental health treatment, to name a few.

How the EAP Program Works

You spend every day trying to make time for everything that’s important to you: your work, your family and your life. Sometimes it can seem as if there’s too much for you to handle. Whether you’re trying to find child care, trying to get out of debt, coping with a family problem or personal issue that’s weighing you down at home or at work, or just dealing with the ups and downs of everyday life, get in touch with Horizon Health if you need help. This service is free and completely confidential. The program can give you information, advice and support on a wide range of everyday issues, including:

- Parenting and child care
- Education
- Elder care issues
- Midlife and retirement
- Financial
- Legal, including free basic Will preparation
- Work
- Managing people
- Health and wellness
- Emotional well-being
- Addiction and recovery
- Grief and loss

Help When You Need It

No matter who you are, no matter what kind of issues you’re dealing with, the Horizon Health EAP is designed to help you find the support, advice, and resources you need 24/7.

You can access EAP benefits by going to www.horizoncarelink.com (company name/user id: Tulane; password: eap) or call 888-293-6948.

Tulane University respects your right to confidentiality in your voluntary contacts with the EAP. Counselors at the EAP have been instructed not to reveal to anyone at Tulane University or elsewhere the names of persons voluntarily using the EAP.
TUWellness Program Highlights
At Tulane our goal is to promote healthier lifestyles within the University community. To do this we offer opportunities for exercise, education, biometric consultations and health assessments.

How TUWellness Works

Physical Activity Programs
In 2010 benefits eligible employees have the option to participate in three physical activity programs:

- 10K-A-Day (February – April): a motivating walking program designed to boost daily activity. Every participant receives a complimentary pedometer and access to the 10K-A-Day website to track their daily steps
- American Heart Association’s Start! Walking Program (June – August): A worksite walking program that allows participants to access the MyStart! Tracker in order to record physical activity and diet intake.
- Plus One Health Management’s Biggest Winner Program (mid-September – mid- November): Based on the popular NBC show “The Biggest Loser”, this program is designed to help participants reach optimal health via nutrition and physical activity with motivational support and team work.

Participants are eligible to win gift card incentives for each program.

Educational Seminars
UHC provides Tulane with several different hour-long educational seminars which all Tulane employees may attend. Examples of seminars include: Making Healthy Food Choices, Natural Energy Boosters, and Aging Well. Nutritional seminars are also available throughout the year.

Communication
TUWellness periodically sends electronic newsletters with all upcoming programs/initiatives held at each campus location. TUWellness also has a twitter account which gives updates on current programs/initiatives at each campus location and can be viewed at www.twitter.com/TUWellness.

Health Risk Assessment
UHC members and their spouses/SGDP’s are eligible to complete their online Health Risk Assessment (HRA). After completing the assessment you may then complete the online health coaching and/or telephonic coaching. By completing the online assessment and/or either coaching you will receive a gift card to choose from over 300 stores nationwide. You can access the HRA by registering on www.myuhc.com. HRA gift cards are subject to regular taxation.
Tuition Waiver Plan Highlights
Eligible employees may receive exemption from the payment of tuition for up to two courses (or six hours, whichever is greater) per semester, at the undergraduate or graduate level. You and your dependents are eligible upon full-time employment.

How the Tuition Waiver Program Works
Eligible employees may receive exemption from tuition for Tulane undergraduate and graduate programs; eligible spouses and dependent children of an eligible employee may receive exemption from the payment of tuition for credit courses at the undergraduate level only. Any University fees required are not included for exemption.

Accessing the Tuition Waiver Program
- The University requires a copy of the employee’s most recent federal income tax return when a tuition waiver is claimed for a dependent child.
- A Tuition Waiver Application form must be completed each semester in which enrollment is requested. Eligibility for tuition waivers is determined when the Tuition Waiver Application is submitted.
- A Tuition Waiver Application must be submitted to the Workforce Management Organization by the applicable deadline. The deadline for applications for a particular academic session can be found on the Workforce Management Organization web site.
- Late Tuition Waiver Applications will not be processed and tuition becomes the employee’s responsibility.
- If the person enrolled in a tuition waiver becomes ineligible for the tuition waiver during a semester, the ineligible person will be allowed to complete the semester in which he or she is enrolled. However, if the person enrolled becomes ineligible for the tuition waiver as a result of such employee’s voluntary termination of employment at any time during the semester, the former employee will be charged for the full tuition amount for that semester.
- In the event that an eligible person drops a course subsequent to the deadline for drop/add, the employee will be charged a $50.00 per class drop fee per course.
- These benefits are contingent upon the University’s admissions guidelines.
- Tuition waivers for employees, spouses and dependent children for undergraduate study are treated as non-taxable educational assistance. Tuition remission for education beyond the undergraduate level which is only available for eligible employees is treated as taxable income to employees under the Internal Revenue Code.

Tuition Waiver Limitations
Tuition waivers are granted for college-level work taken for credit and do not include workshops or non-credit seminars or the following programs:
- Civic and Cultural Management Program
- Executive Master of Business Administration (EMBA)
- Executive Master of Health Administration
- Executive Master of Medical Management
- Master of Science in Cell and Molecular Biology
- Master of Science in Pharmacology
- Freeman Summer School Abroad
- Law School

Graduate-Level Tuition Waivers
Graduate-level tuition waivers for University employees can be provided on a tax-free basis up to $5,250 annually.
Employees enrolled in the PMBA program in the A.B. Freeman School of Business will be approved to take seven hours in one semester as required by the PMBA curriculum, and in light of the fact that a future semester requires only five hours of coursework. The approval to exceed the six hour credit limit per semester applies only to employees enrolled in the PMBA program and will only be approved for one semester.

Please contact WFMO to determine whether a program is covered by this policy. Tuition waiver will not be granted to any eligible person for taking a previously completed course a second time.

**Vacation**
Administrative Officers receive four weeks of vacation per year.

**Holidays**
Tulane has regularly scheduled and discretionary paid holidays; discretionary holidays are denoted below with an asterisk and are determined each year. A new holiday schedule is announced each year and includes the following:

- Independence Day
- Labor Day
- Thanksgiving (2 days)
- Christmas Holidays (2 days)*
- New Year’s Holidays
- Martin Luther King’s Birthday
- Lundi Gras*
- Mardi Gras Day*
- Good Friday
- Memorial Day
- Winter Recess*
### Benefit Plan Contacts

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Vendor or Department</th>
<th>Group, Plan or I.D. Number</th>
<th>Phone Number</th>
<th>Web Site</th>
</tr>
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<tr>
<td>Medical Plan</td>
<td>UnitedHealthcare</td>
<td>702888</td>
<td>866-633-2446</td>
<td><a href="http://www.myuhc.com">www.myuhc.com</a></td>
</tr>
<tr>
<td>Dental Plan</td>
<td>MetLife</td>
<td>102287</td>
<td>800-942-0854</td>
<td><a href="http://www.metlifedental.com">www.metlifedental.com</a></td>
</tr>
<tr>
<td>Vision Plan</td>
<td>EyeMed</td>
<td>9704446</td>
<td>866-723-0513</td>
<td><a href="http://www.enrollwitheyemed.com/access">www.enrollwitheyemed.com/access</a></td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td>Benefit Concepts</td>
<td>N/A</td>
<td>800-969-2009</td>
<td><a href="http://www.benefitconcepts.com">www.benefitconcepts.com</a></td>
</tr>
<tr>
<td>Employee Assistance Plan</td>
<td>Horizon Health</td>
<td>N/A</td>
<td>888-293-6948</td>
<td><a href="http://www.horizoncarelink.com">www.horizoncarelink.com</a></td>
</tr>
<tr>
<td>Life &amp; AD&amp;D Insurance</td>
<td>WFMO – Benefits Team</td>
<td>N/A</td>
<td>504-865-5280</td>
<td><a href="http://www.tulane.edu/wfmo">www.tulane.edu/wfmo</a></td>
</tr>
<tr>
<td>Business Travel Accident Insurance</td>
<td>WFMO – Benefits Team</td>
<td>9906-39-63</td>
<td>504-865-5280</td>
<td><a href="http://www.tulane.edu/wfmo">www.tulane.edu/wfmo</a></td>
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<tr>
<td>Long-Term Disability</td>
<td>WFMO – Benefits Team</td>
<td>N/A</td>
<td>504-865-5280</td>
<td><a href="http://www.tulane.edu/wfmo">www.tulane.edu/wfmo</a></td>
</tr>
<tr>
<td>403(b) Plan</td>
<td>Fidelity Investments</td>
<td>54695</td>
<td>888-842-9001</td>
<td><a href="http://www.netbenefits.fidelity.com">www.netbenefits.fidelity.com</a></td>
</tr>
<tr>
<td>403(b) and 457(b) Plans</td>
<td>TiAA-CREF</td>
<td>100221</td>
<td>877-518-9161</td>
<td><a href="http://www.tiaa-cref.org">www.tiaa-cref.org</a></td>
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<tr>
<td>Tuition Waiver Program</td>
<td>WFMO – Benefits Team</td>
<td>N/A</td>
<td>504-865-5280</td>
<td><a href="http://www.tulane.edu/wfmo">www.tulane.edu/wfmo</a></td>
</tr>
<tr>
<td>Vacation &amp; Sick Time Accrual</td>
<td>WFMO Payroll</td>
<td>N/A</td>
<td>504-865-5280</td>
<td><a href="http://www.tulane.edu/wfmo">www.tulane.edu/wfmo</a></td>
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<tr>
<td>TU Wellness Programs</td>
<td>PlusOne Wellness Coordinator</td>
<td>N/A</td>
<td>504-865-5280</td>
<td><a href="http://www.tulane.edu/wfmo">www.tulane.edu/wfmo</a></td>
</tr>
<tr>
<td>Employee Recognition</td>
<td>WFMO Customer Relations</td>
<td>N/A</td>
<td>504-865-5280</td>
<td><a href="http://www.tulane.edu/wfmo">www.tulane.edu/wfmo</a></td>
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<tr>
<td>COBRA and Direct Billing</td>
<td>Crosby Benefits</td>
<td>N/A</td>
<td>800-462-2235</td>
<td><a href="http://www.crosbybenefits.com">www.crosbybenefits.com</a></td>
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Important Notices and Information

This section covers the following important federally-required notices and information:

- Certificate of Creditable Coverage, Important Notice About Your Prescription Drug Coverage and Medicare
- COBRA Rights Notification
- Continuing Health Coverage During a Military Leave
- Medicaid and the Children’s Health Insurance Program (CHIP)
- Mental Health Parity and Tulane Medical Coverage
- Newborns’ and Mothers’ Health Protection Act
- Notice of Privacy Practices
- Qualified Medical Child Support Orders
- Women’s Health and Cancer Rights Act Of 1998

Certificate of Creditable Coverage, Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Tulane and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Tulane has determined that the prescription drug coverage offered by Tulane through United Healthcare is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition, if you lose or decide to leave Employer-sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. If you do decide to enroll in a Medicare prescription drug plan and drop your Tulane medical coverage, which includes prescription drug coverage, be aware that you and your dependents cannot get this coverage back unless you are still an active employee and you enroll during open enrollment or because you’ve experienced a qualifying change in status event.

Please contact WFMO for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan. You should also know that if you drop or lose your prescription drug coverage with Tulane and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends; you may pay a higher premium (a penalty) to join a Medicare drug plan later.
If you go 63 continuous days or longer without prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

Note: You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through Tulane changes. You also may request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. You’ll get a copy of this handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**COBRA Rights Notification**

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of health coverage (called “continuation coverage” or COBRA coverage) in certain instances when coverage under a group health plan would otherwise end. A group health plan includes any major medical plan, dental plan, vision plan, health FSA, or other plan that employers may maintain and that provides medical care. For simplicity, any such group health plan is referred to in this Notice as the “Plan.” You do not have to show that you are insurable to elect continuation coverage; however, you will have to pay the entire premium for your continuation coverage. At the end of the maximum coverage period (described below), you will be allowed to enroll in an individual conversion health plan if it is otherwise available under the Plan, subject to the requirement to pay the premiums required by the individual conversion health plan. This Notice provides a brief overview of your rights and obligations under current law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly. Both you (the employee) and your spouse should read this summary carefully and keep it with your records!

**Qualifying Events**

If you are the employee of the Employer and are covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any one of the two “qualifying events”:

- Termination of employment (for reasons other than gross misconduct).
- Reduction in the hours of your employment.

If you are the spouse of an employee covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four “qualifying events”:

- The death of your spouse.
- A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment with the Employer.
- Divorce or legal separation from your spouse. (Also, if an employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex spouse notifies the administrator within 60 days after the later divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)

- Your spouse becomes entitled to Medicare benefits.

In the case of a dependent child of an employee covered by the Plan, the dependent child has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five “qualifying events”:

- The death of the employee-parent.
- The termination of the employee-parent’s employment (for reasons other than gross misconduct) or reduction in the employee-parent’s hours of employment with the Employer.
- Parent’s divorce or legal separation.
- The employee-parent becomes entitled to Medicare benefits.
- The dependent ceases to be a “dependent child” under the Plan.

Your Notice Obligations

If your spouse or dependent child loses coverage under the Plan because of divorce, legal separation or the child’s losing dependent status under the Plan, then you (the employee) or your spouse or dependent has the responsibility to notify Tulane of the divorce, legal separation, or the child’s losing dependent status. You or your spouse or dependent must provide this notice no later than 60 days after the date coverage terminates under the plan. If you or your spouse or dependent child fails to provide this notice to Tulane during this 60-day notice period, any spouse or dependent child who loses coverage will NOT be offered to elect continuation coverage. Furthermore, if you or your spouse or dependent child fails to provide this notice to Tulane, and if any claims are mistakenly paid for expenses after the date coverage terminate upon the divorce, legal separation, or a child’s losing dependent status, then you, your spouse, and your dependent children will be required to reimburse the Plan for any claims so paid.

If Tulane is timely provided with the notice of a divorce, legal separation, or a child’s losing dependent status that caused a loss of coverage, then Tulane will notify the affected family member of the right to elect continuation coverage (but only to the extent that Tulane has been notified in writing of the affected family member’s current mailing address). Tulane will also notify you (the employee), your spouse and dependent children of the right to elect continuation coverage after it receives notice of the following events that results in a loss of coverage: the employee’s termination of employment (other than for gross misconduct), reduction in hours, or death, or the employee’s becoming entitled for Medicare.

Election Procedures

You (the employee) and/or your spouse and dependent children must elect continuation coverage within 60-days after Plan coverage ends, or, if later, 60 days after Tulane provides you or your family member with notice of the right to elect continuation coverage. If you or your spouse and dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage. A COBRA election mailed to Tulane is considered to be mailed on the date of mailing. You (the employee) and/or your spouse and dependent children may elect continuation coverage for all qualifying family members. You, your spouse and dependent children each have an independent right to elect continuation coverage. Thus, a spouse or dependent child may elect continuation coverage even if the covered employee does not elect it. You (the employee) and/or your spouse and dependent children may elect continuation coverage even if covered under another employer-sponsored group health plan or entitled to Medicare.


Type of Coverage
Ordinarily, the continuation coverage that is offered will be the same coverage that you, your spouse or dependent children had on the day before the qualifying event. Therefore, an employee, spouse or dependent child who is not covered under the Plan on the day before the qualifying event generally is not entitled to COBRA coverage except, for example, when there is no coverage because it was eliminated in anticipation of a qualifying event such as divorce. If the coverage is modified for similarly-situated employees or their spouses or dependent children, then COBRA coverage will be modified in the same way. If the Employer maintains more than one group health plan (or offers a choice of separate benefit packages under a single plan), you (or your spouse or dependent children) may elect COBRA coverage under one or more of those plans (or separate benefit packages) in which you have coverage. For example, if you are covered under three separate employer plans (e.g., a medical plan, a dental plan, and a vision plan), you could elect COBRA coverage under the medical plan and decline coverage under either or both of the dental and vision plans. But if the employer maintains one consolidated group health plan (for example, one that provides medical, dental, and vision benefits under a single plan), you must elect or decline COBRA coverage for the plan as a whole.

You (or your spouse or dependent children) may elect to continue the Healthcare FSA coverage under COBRA, but only if there is a positive account balance (i.e., year-to-date contributions exceed year-to-date claims) on the day before the qualifying event (taking into account all claims submitted by that date). COBRA coverage under the Healthcare FSA will continue only for the remainder of the Plan year in which the qualifying event occurred. If there is a negative account balance (i.e., year-to-date contributions are less than year-to-date claims), then no qualified beneficiary may elect COBRA coverage under the Healthcare FSA.

COBRA Premiums That You Must Pay
The premium payments for the “initial premium months” must be paid for you (the employee) and for any spouse or dependent children by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the election of continuation coverage is made. Once continuation coverage is elected, the right to continue coverage is subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial premium month until the month’s premium is paid within the 45-day period after the election of continuation coverage is made. All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period.

A premium payment that is mailed is considered to be made on the date it is sent. If you don’t make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the 1st of the month, with no possibility of reinstatement.

Maximum Coverage Periods
The maximum duration for COBRA coverage is described below. COBRA coverage terminates before the maximum coverage period in certain situations described later under the heading “Termination of COBRA Coverage before the End of the Maximum Coverage Period.”

- 36 Months. If you (the spouse or dependent child) lose group health coverage because of the employee’s death, divorce, legal separation, or the employee’s becoming entitled to Medicare, or because you lose your status as a dependent child under the Plan, then the maximum coverage period (for spouse and dependent child) is three years from the date of the qualifying event.
- 18 Months. If you (the employee, spouse or dependent child) lose group health coverage because of the employee’s termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage is 18 months for the date of termination or reduction in hours. There are three exceptions:
If an employee or family member is disabled at any time during the first 60 days after the date of termination of employment or reduction in hours, then the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under Social Security Act must be provided to Tulane within both the 18-month coverage period and 60 days after the date of the determination.

If a second qualifying event that gives rise to a 36-month maximum coverage period for the spouse or dependent child (for example, the employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, then the maximum coverage period (for a spouse or dependent child) becomes three years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to Tulane within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension of COBRA coverage will occur.

If the qualifying event occurs within 18 months after the employee becomes entitled to Medicare, then the maximum coverage period (for the spouse and the dependent child) is three years from the date the employee became entitled to Medicare.

Shorter Maximum for Healthcare FSA’s
The maximum COBRA period for a Healthcare FSA (if there is a positive account balance as of the date of the qualifying event, as previously explained) ends on the last day of the Plan year in which the qualifying event occurred. If there is a negative balance as of the date of the qualifying event, no COBRA coverage will be offered.

Children Born to or Placed for Adoption with the Covered Employee during COBRA Period
A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary, provided that, the covered employee has elected continuation coverage for himself or herself. The child’s COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Open Enrollment Rights and HIPAA Special Enrollment Rights
Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly-situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, HIPAA’s special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add coverage for dependents if such person acquires a new dependent (through marriage, birth, adoption or placement for adoption), or if an eligible dependent declines coverage because of other coverage and later loses such coverage due to certain qualifying reasons. Except for certain children described above under “Children born to or Placed for Adoption With the Covered Employee During COBRA Period,” dependents who are enrolled in a special enrollment period or open enrollment period do not become qualified beneficiaries and their coverage will end and at the same time that coverage ends for the person who elected COBRA and later added them as dependents.

Alternate Recipients under QMCSOs
A child of yours (the employee’s) who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by Tulane during your (the employee’s) period of employment with the employer is entitled to the same rights under COBRA as a dependent child of yours, regardless of whether that child would otherwise be considered your dependant.
Termination of COBRA Coverage before the End of Maximum Coverage Period

Continuation coverage of the employee, spouse and/or dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs.

- The Employer no longer provides group health coverage to any of its employees.
- The premium for the qualified beneficiary’s COBRA coverage is not timely paid.
- After electing COBRA, you (the employee, spouse or dependent child) become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note that under HIPAA, an exclusion or limitation of the group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.)
- After electing COBRA coverage, you (the employee, spouse or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
- You (the employee, spouse or dependent child) became entitled to a 29-month maximum coverage period due to disability of qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than the 30 days after the determination).
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

Address, Marital, Dependent and Disability Status Changes
If you or your spouse’s address changes, you must promptly notify Tulane in writing (Tulane needs up-to-date addresses in order to mail important COBRA notices and other information). Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the Plan terms, you or your spouse or your dependent must promptly notify Tulane in writing (such notification is necessary to protect COBRA right for your spouse and dependent children). In addition, you must notify us if a disabled employee or family member is determined to be no longer disabled.

For More Information
If you, your spouse or dependent children have any questions about this notice or COBRA, please contact the Plan Administrator if you wish to receive the most recent copy of the Plan’s Summary Plan Description, which contains important information about Plan benefits, eligibility, exclusions and limitations.

Continuing Health Coverage during a Military Leave
In accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA), if you are called into military service (active duty or inactive duty training), you may continue coverage under the Tulane medical, dental and vision plans during a USERRA leave as long as you continue to make the required contributions.
Generally, you may continue your coverage through the 18-month period beginning on the date on which your USERRA leave begins or through the period ending on the day after the date on which you fail to return to a position of employment with Tulane University, as determined in accordance with USERRA, whichever ends earlier. If your USERRA leave is 31 days or longer, you may be required to pay up to 102 percent of the required contributions.
If the USERRA leave is for less than 31 days, your required contributions will remain the same as similarly situated active employees. Note that coverage provided under USERRA will run concurrently with any right-to-continue coverage under COBRA. To be eligible for USERRA benefits, you are generally required to give advance notice of your military leave to WFMO.

**Medicaid and the Children’s Health Insurance Program (CHIP)**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in Louisiana or one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 22, 2010. You should contact your State for further information on eligibility.

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<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
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<tr>
<td>ALABAMA – Medicaid</td>
<td>Website: <a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a></td>
<td>Phone: 1-800-362-1504</td>
<td></td>
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<tr>
<td>ALASKA – Medicaid</td>
<td>Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a></td>
<td>Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529</td>
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<tr>
<td>ARIZONA – CHIP</td>
<td>Website: <a href="http://www.azahcccs.gov/applicants/default.aspx">http://www.azahcccs.gov/applicants/default.aspx</a></td>
<td>Phone: 602-417-5422</td>
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<td>ARKANSAS – CHIP</td>
<td>Website: <a href="http://www.arkidsfirst.com/">http://www.arkidsfirst.com/</a></td>
<td>Phone: 1-888-474-8275</td>
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<tr>
<td>GEORGIA – Medicaid</td>
<td>Website: <a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a> Click on Programs, then Medicaid</td>
<td>Phone: 1-800-869-1150</td>
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<tr>
<td>MONTANA – Medicaid</td>
<td>Website: <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a></td>
<td>Telephone: 1-800-694-3084</td>
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<td>CALIFORNIA – Medicaid</td>
<td>Website: <a href="http://www.dhcs.ca.gov/Pages/default.aspx">http://www.dhcs.ca.gov/Pages/default.aspx</a></td>
<td>Phone: 1-800-635-2570</td>
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<td>Colorado – Medicaid and CHIP</td>
<td>Medicaid Website: <a href="http://www.colorado.gov/">http://www.colorado.gov/</a> Medicaid Phone: 1-800-866-3513 CHIP Website: <a href="http://www.CHPltus.org">http://www.CHPltus.org</a> CHIP Phone: 303-866-3243</td>
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<td>Florida – Medicaid</td>
<td>Website: <a href="http://www.fdhc.state.fl.us/Medicaid/index.shtml">http://www.fdhc.state.fl.us/Medicaid/index.shtml</a></td>
<td>Phone: 1-866-762-2237</td>
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<td>Montana – Medicaid</td>
<td>Website: <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a></td>
<td>Telephone: 1-800-694-3084</td>
<td></td>
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<tr>
<td>State</td>
<td>Medicaid and CHIP</td>
<td>Medicaid</td>
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<td>IDAHO</td>
<td>Medicaid Website: <a href="http://www.accesstohealthinsurance.idaho.gov">www.accesstohealthinsurance.idaho.gov</a>&lt;br&gt;Medicaid Phone: 208-334-5747&lt;br&gt;CHIP Website: <a href="http://www.medicaid.idaho.gov">www.medicaid.idaho.gov</a>&lt;br&gt;CHIP Phone: 1-800-926-2588</td>
<td>Website: <a href="http://www.dhhs.ne.gov/med/medindex.htm">http://www.dhhs.ne.gov/med/medindex.htm</a>&lt;br&gt;Phone: 1-877-255-3092</td>
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<td>NEBRASKA</td>
<td>Website: <a href="http://www.dhss.ne.gov/med/index.htm">http://www.dhss.ne.gov/med/index.htm</a>&lt;br&gt;Medicaid Phone: 1-800-992-0900&lt;br&gt;CHIP Website: <a href="http://www.nevadacheckup.nv.org/">http://www.nevadacheckup.nv.org/</a>&lt;br&gt;CHIP Phone: 1-877-543-7669</td>
<td>Medicaid Website: <a href="http://www.accesstohealthinsurance.idaho.gov">http://www.accesstohealthinsurance.idaho.gov</a>&lt;br&gt;Medicaid Phone: 208-334-5747&lt;br&gt;CHIP Website: <a href="http://www.medicaid.idaho.gov">www.medicaid.idaho.gov</a>&lt;br&gt;CHIP Phone: 1-800-926-2588</td>
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<td>INDIANA</td>
<td>Website: <a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a>&lt;br&gt;Phone: 1-877-438-4479</td>
<td>Medicaid Website: <a href="http://www.medicaid.idaho.gov">http://www.medicaid.idaho.gov</a>&lt;br&gt;CHIP Website: <a href="http://www.nevadacheckup.nv.org/">http://www.nevadacheckup.nv.org/</a>&lt;br&gt;CHIP Phone: 1-877-543-7669</td>
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<td>IOWA</td>
<td>Website: <a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a>&lt;br&gt;Phone: 1-888-346-9562</td>
<td>Medicaid Website: <a href="http://www.medicaid.idaho.gov">http://www.medicaid.idaho.gov</a>&lt;br&gt;CHIP Website: <a href="http://www.nevadacheckup.nv.org/">http://www.nevadacheckup.nv.org/</a>&lt;br&gt;CHIP Phone: 1-877-543-7669</td>
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<td>KANSAS</td>
<td>Website: <a href="https://www.khpa.ks.gov">https://www.khpa.ks.gov</a>&lt;br&gt;Phone: 1-800-635-2570</td>
<td>Medicaid Website: <a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a>&lt;br&gt;Phone: 1-877-438-4479</td>
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<td>KENTUCKY</td>
<td>Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a>&lt;br&gt;Phone: 1-800-635-2570</td>
<td>Medicaid Website: <a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a>&lt;br&gt;Phone: 1-877-438-4479</td>
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<td>LOUISIANA</td>
<td>Website: <a href="http://www.dhh.louisiana.gov/offices/?ID=92">www.dhh.louisiana.gov/offices/?ID=92</a>&lt;br&gt;Phone: 1-888-342-0555</td>
<td>Medicaid Website: http://www._1stmedicaid.com&lt;br&gt;Phone: 1-800-635-2570</td>
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<td>MAINE</td>
<td>Website: <a href="http://www.main.gov/dhhs/oms/">http://www.main.gov/dhhs/oms/</a>&lt;br&gt;Phone: 1-800-321-5557</td>
<td>Medicaid Website: <a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a>&lt;br&gt;Phone: 1-877-438-4479</td>
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<td>MASSACHUSETTS</td>
<td>Medicaid &amp; CHIP Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a>&lt;br&gt;Medicaid &amp; CHIP Phone: 1-800-462-1120</td>
<td>Medicaid Website: <a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a>&lt;br&gt;Phone: 1-877-438-4479</td>
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<td>MINNESOTA</td>
<td>Website: <a href="http://www.dhs.state.mn.us/health-care">http://www.dhs.state.mn.us/health-care</a>, then Health Assistance&lt;br&gt;Phone: 800-657-3739</td>
<td>Medicaid Website: <a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a>&lt;br&gt;Phone: 1-877-438-4479</td>
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<td>MISSOURI</td>
<td>Website: <a href="http://www.dss.mo.gov/mhd/index.htm">http://www.dss.mo.gov/mhd/index.htm</a>&lt;br&gt;Phone: 573-751-6944</td>
<td>Medicaid Website: <a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a>&lt;br&gt;Phone: 1-877-438-4479</td>
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<td>NEW HAMPSHIRE</td>
<td>Medicaid Website: <a href="http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm">http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm</a>&lt;br&gt;Phone: 1-800-522-5265&lt;br&gt;CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>&lt;br&gt;CHIP Phone: 1-800-701-0710</td>
<td>Medicaid Website: <a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a>&lt;br&gt;Phone: 1-877-438-4479</td>
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<td>NEW JERSEY</td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmhs/clients/medicaid">http://www.state.nj.us/humanservices/dmhs/clients/medicaid</a>&lt;br&gt;Medicaid Phone: 1-800-356-1561&lt;br&gt;CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>&lt;br&gt;CHIP Phone: 1-800-701-0710</td>
<td>Medicaid Website: <a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a>&lt;br&gt;Phone: 1-877-438-4479</td>
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<td>NEW MEXICO</td>
<td>Medicaid Website: <a href="http://www.hsd.state.nm.us/mad/index.html">http://www.hsd.state.nm.us/mad/index.html</a>&lt;br&gt;CHIP Website: <a href="http://www.hsd.state.nm.us/mad/index.html">http://www.hsd.state.nm.us/mad/index.html</a>&lt;br&gt;Click on Insure New Mexico&lt;br&gt;CHIP Phone: 1-888-997-2583</td>
<td>Medicaid Website: <a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a>&lt;br&gt;Phone: 1-877-438-4479</td>
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<td>NEW YORK</td>
<td>Medicaid Website: <a href="http://www.nyhealth.gov/health_care/medicaid">http://www.nyhealth.gov/health_care/medicaid</a>&lt;br&gt;Phone: 1-800-541-2831</td>
<td>Medicaid Website: <a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a>&lt;br&gt;Phone: 1-877-438-4479</td>
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<td>NORTH CAROLINA</td>
<td>Medicaid Website: <a href="http://www.nc.gov">http://www.nc.gov</a>&lt;br&gt;Phone: 919-855-4100</td>
<td>Medicaid Website: <a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a>&lt;br&gt;Phone: 1-877-438-4479</td>
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<td>State</td>
<td>Program</td>
<td>Website</td>
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<td>OKLAHOMA</td>
<td>Medicaid</td>
<td><a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
<td>1-888-365-3742</td>
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<td>PENNSYLVANIA</td>
<td>Medicaid</td>
<td><a href="http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm">http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm</a></td>
<td>1-800-644-7730</td>
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<td>RHODE ISLAND</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.ri.gov">www.dhs.ri.gov</a></td>
<td>401-462-5300</td>
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<td>WEST VIRGINIA</td>
<td>Medicaid</td>
<td><a href="http://www.wvrecovery.com/hipp.htm">http://www.wvrecovery.com/hipp.htm</a></td>
<td>304-342-1604</td>
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<td>SOUTH CAROLINA</td>
<td>Medicaid</td>
<td><a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
<td>1-888-549-0820</td>
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<td>WISCONSIN</td>
<td>Medicaid</td>
<td><a href="http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm">http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm</a></td>
<td>1-800-362-3002</td>
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<td>TEXAS</td>
<td>Medicaid</td>
<td><a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a></td>
<td>1-800-440-0493</td>
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To see if any more States have added a premium assistance program since January 22, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
[www.cms.hhs.gov](http://www.cms.hhs.gov)
1-877-267-2323, Ext. 61565
Mental Health Parity and Tulane Medical Coverage

The Mental Health Parity and Addiction Equity Act (MHPAEA) is a recent amendment to the Mental Health Parity Act of 1996. These laws preclude medical plans from imposing financial requirements and treatment limitations on mental health or substance abuse benefits that are more restrictive than financial requirements and treatment limitations on medical and surgical benefits. MHPAEA also may prevent your large group health plan from placing annual or lifetime dollar limits on Mental Health and Substance Abuse benefits that are less favorable than annual or lifetime dollar limits for medical and surgical benefits offered under the plan.

Although the law requires "parity", or equivalence, with regard to annual and lifetime dollar limits, financial requirements and treatment limitations, MHPAEA does not require group health plans and their health insurance issuers to include these benefits in their medical plan.

Key changes made by MHPAEA include the following:

- If a group health plan includes medical and surgical benefits and mental health and substance abuse benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health and substance abuse benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical and surgical benefits;
- Mental health and substance abuse benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits;
- If a group health plan includes medical and surgical benefits and mental health and substance abuse benefits, and the plan provides for out of network medical and surgical benefits, it must provide for out of network mental health and substance abuse benefits;
- Standards for medical necessity determinations and reasons for any denial of benefits relating to mental health and substance abuse benefits must be disclosed upon request;

Newborns’ and Mothers’ Health Protection Act

Federal law generally prohibits restricting benefits for hospital lengths of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery and less than 96 hours following a cesarean section. However, federal law does not generally prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Tulane medical plans may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities or to reduce your out-of-pocket costs, you may be required to obtain precertification.

Notice of Privacy Practices

Tulane University is committed to protecting the privacy of health information maintained by various University benefit plans or by outside vendors who perform administrative services for Tulane (hereafter referred to as “The Plan”). The Plan is required by law to protect the privacy of certain health information that may reveal your identity, and to provide you with a copy of this notice which describes the Plan’s health information privacy practices. If you have any questions about this notice or would like further information, please contact the Privacy Official at (504) 988-7739.

This Notice does not apply to certain information which may be used and disclosed by Tulane University and other third parties without notice and without your authorization. For instance, Tulane University and Tulane University’s consultants and contractors may use and disclose information contained in your employment records held by Tulane University in its role as employer, including information regarding pre-employment health testing.
In addition Tulane University and Tulane University’s consultants and contractors may use and disclose information concerning certain benefits, such as disability and life insurance, and your eligibility and enrollment in the Plan without notice and without your authorization. These benefits are not covered by Federal privacy regulations or this Notice.

What Health Information Is Protected?
The Plan is committed to protecting the privacy of health information maintained by the Plan. Some examples of protected health information are:

- information regarding payment for your health care (such as your enrollment in a health plan);
- information about your health condition (such as a disease you may have);
- information about health care services you have received or may receive in the future (such as an operation);
- unique numbers that may identify you (such as your social security number, your phone number, or your driver’s license number as listed on claims forms or health referral forms); and
- other types of information that may identify who you are such as geographic information.

The only health information covered by this Notice is information maintained by the Plan and not by Tulane University. The type of health information typically maintained by the Plan includes the claims information you submit, benefit determination records, appeals information, and eligibility and case management information.

Summary Of Permissible Uses And Disclosures And Your Rights Regarding Your Health Information

Requirement of Written Authorization
The Plan will generally obtain your written authorization before using your health information or sharing it with others outside the Plan except as otherwise described in this notice. If you provide the Plan with written authorization, you may revoke that authorization at any time, except to the extent that the Plan has already relied on it. To revoke an authorization, please write to the Benefits Specialist for the Plan, Attention WFMO.

Exception to Written Authorization. There are some situations when the Plan will not require your written authorization before using your health information or sharing it with others. They are:

- **Payment.** The Plan may use and disclose your health information for purposes of reimbursement for your health care services. The Plan may also use and disclose your health information to make determinations about your eligibility for insurance coverage under the FSA Group Health Plan. In addition, the Plan may disclose eligibility and enrollment information to Tulane University for these purposes. Once received, Tulane University may only disclose your health information to third parties, such as to consultants or advisors, if Tulane University has first obtained a confidentiality agreement from the person or organization receiving your health information.

- **Health Care Operations.** The Plan may use and disclose your health information to conduct normal business operations. For example, the Plan may use your health information to evaluate the performance of the staff in managing and providing you with health care benefits. The Plan also may use and disclose your health information to investigate the validity of benefits claims. In addition, the Plan may share your health information with another company that performs certain services, such as legal or auditing services or benefits consulting. Whenever the Plan has such an arrangement, it will have a written confidentiality agreement to ensure that the company that performs these services will protect the privacy of your health information, maintain its confidentiality and limit the uses or further disclosures to the purpose for which the information was disclosed or to those required by law. In addition, Tulane University may receive and disclose your health information to third parties if Tulane University has obtained a confidentiality agreement from the person or organization receiving your health information.

- **Benefits and Services.** As part of our health care operations, the Plan may use your health information to contact you regarding benefits or services that may be of interest to you, such as benefits that are included in the Plan.
• **Tulane University as Employer.** The Plan may disclose certain portions of your health information to Tulane University. Upon a request from Tulane University, the Plan may disclose health information about you to enable Tulane University to modify, amend, or terminate the Plan; however, the information the Plan discloses will not include any information that identifies you other than your zip code. The Plan may also disclose to Tulane University information on whether you are participating in, enrolled in, or disenrolled from the Plan. The Plan also may disclose health information about you, including information that identifies you, as necessary for Tulane University to administer the Plan. For example, Tulane University may need such information to process health benefits claims, to audit or monitor the business operations of the Plan, or to ensure that the Plan is operating effectively and efficiently. The Plan, however, will restrict Tulane University’s uses of your information to purposes related only to Plan administration. The Plan prohibits Tulane University from using your information for uses unrelated to Plan administration. Under no circumstances will the Plan disclose your health information to Tulane University for the purpose of employment-related actions or decisions (e.g., for employment termination) or for the purpose of administering any other plan that Tulane University may offer. Once received, Tulane University may only disclose your health information to third parties, such as to consultants or advisors, if Tulane University has first obtained a confidentiality agreement from the person or organization receiving your health information.

• **Disclosures to Friends and Family Involved in Your Care and Payment for Your Care.** The Plan may share information about your health benefits with your friends and family involved in your care or payment for your care unless you object. If you have provided your family members or close friends with your Social Security Number, the Plan will assume that you do not object unless you call or write the Plan to state your objection.

• **Information that Does Not Identify You.** The Plan may use or disclose your health information if the Plan has removed any information that might reveal who you are, or for limited purposes if the Plan has removed most information revealing who you are and obtained a confidentiality agreement from the person or organization receiving your health information.

• **As Required By Law.** The Plan may use or disclose your health information if the Plan is required by law to do so. The Plan will notify you of these uses and disclosures if notice is required by law.

• **Other Uses and Disclosures.** While federal law allows health plans to use and disclose plan members' information for treatment purposes and for other purposes to benefit the public (e.g., for scientific research) without authorization, the Plan does not currently use or disclose its members' information in these ways. The Plan promises not to use or disclose your information for such purposes in the future without your authorization. Federal law prohibits the Plan from breaking this promise to you.

**Access and Control of Your Health Information.** The Plan must provide you certain rights with respect to access and control of your health information in your FSA file. To the extent that the Plan has provided your information to a business associate, e.g., a third party administrator of your health benefits, you must request access directly from such business associate. You have the following rights to access and control your health information:

- **Access.** You generally have the right to inspect and copy your health information.
- **Amendments.** You have the right to request that the Plan amend your health information if you believe it is inaccurate or incomplete. For example, if you have amended information contained in your provider medical record for which a health care claim has been filed, you may also wish to request the same information be amended in your benefit file.
- **Tracking the Ways Your Health Information Has Been Shared with Others.** You have the right to receive a list from the Plan, called an “accounting list,” which provides information about when and how the Plan has disclosed your health information to outside persons or organizations. Many routine disclosures the Plan makes, including disclosures to Tulane University for the purposes of administering the Plan, will not be included on this list. The list will identify only non-routine disclosures of your information.
- **Additional Privacy Protections.** You have the right to request further restrictions on the way the Plan uses your health information or shares it with others. The Plan is not required to agree to the restriction you request, but if the Plan does, the Plan will be bound by the agreement.
Confidential Communications. You have the right to request that the Plan contact you in a way that is more confidential for you, such as at work instead of at home, if disclosure of your health information could put you in danger and you clearly state that in your request. The Plan will try to accommodate all reasonable requests.

To Have Someone Act on Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information.

Copies of Notice. You may request a paper copy of this Notice at anytime. The Plan will be required by law to abide by its terms that are currently in effect. However, the Plan also may change its privacy practices from time to time. If that happens, the Plan will revise this notice so you will have an accurate summary of the Plan’s practices. The revised notice will apply to all of your health information. To request a paper copy of this notice or any revised notice, please call the Privacy Official at 504/988-7739. If this notice is substantially revised, a new notice will be mailed to you within 60 days. The effective date of the notice will always be located in the top right corner of the first page.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, please contact the Privacy Official, 1430 Tulane Avenue, TW3, New Orleans, LA 70112, 504/988-7739. No one will retaliate or take action against you for filing a complaint.

Qualified Medical Child Support Orders
If you are enrolled in a Tulane medical plan and you are required under a “qualified medical child support order” (as that term is defined under ERISA) to provide coverage for a minor dependent child, you may enroll such minor dependent child included in the order at any time following the date on which the order was signed by a competent court or administrative agency. Tulane University will determine whether an order is a qualified medical child support order and whether such child is eligible for coverage under the qualified medical child support order.

Women’s Health and Cancer Rights Act Of 1998
The Women’s Health and Cancer Rights Act of 1998 requires that a group health plan (or a health insurance issuer) providing health insurance coverage that provides medical and surgery benefits for mastectomies to participants or beneficiaries, to cover:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. Annual deductibles and coinsurance consistent with those applied to other benefits can be applied. In addition to the above, a group health plan or issuer may not:

- Deny a patient eligibility, or continued eligibility, to enroll, or to renew coverage, in the plan, solely for the purpose of avoiding the requirements of this section; and
- Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.